

**GUIDELINES FOR MANAGEMENT OF POST TRAUMATIC STRESS DISORDER  
AMONG SOUTH AFRICAN POLICE SERVICE WORKERS IN MAHIKENG, NORTH  
WEST PROVINCE OF SOUTH AFRICA**

by

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submitted in accordance with the requirements

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February 2015

Student number: 492-171-51

### **DECLARATION**

I declare that **GUIDELINES FOR MANAGEMENT OF POST TRAUMATIC STRESS DISORDER AMONG SOUTH AFRICAN POLICE SERVICE WORKERS IN MAHIKENG, NORTH WEST PROVINCE OF SOUTH AFRICA** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

A handwritten signature in black ink, appearing to read 'SM Maabela', is written over a light gray grid background.

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**SIGNATURE**  
(SM Maabela)

February 2015  
**Date**

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AMONG SOUTH AFRICAN POLICE SERVICE WORKERS IN MAHIKENG, NORTH  
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**ABSTRACT**

Police workers have to contend with a variety of traumatic incidents in their daily work. This includes work, personal and socio-economic stressors. These, if not managed, may lead to Post Traumatic Stress Disorder (PTSD). The aim of this study was to develop guidelines to assist the South African Police Service (SAPS) organisation to provide appropriate interventions for workers diagnosed with work and non-work-related PTSD in the Mahikeng area of the North West Province in South Africa. The study further sought to assist the workers' immediate family members to cope with living with a member diagnosed with PTSD. A qualitative research method was used. Data was collected using self-administered in-depth interviews. The study sample comprised of 19 SAPS workers and 23 family members. Data was analysed using the Statistical Package for the Social Sciences (SPSS) version 20.0. The Excel computer program was used to identify and analyse common themes.

A lower PTSD prevalence rate of 0.76% was yielded by the results. Work-related traumatic incidents were linked to possible PTSD development for most SAPS workers. Exposure to traumatic incidents might have had a substantial effect on participants' health and social lives as most developed varying health conditions post to the PTSD diagnosis.

Living with a member diagnosed with PTSD brought trauma, financial problems and constant worry among families. Families coped by supporting each other. The provision of counseling services and active participation in PTSD support groups and sport activities were identified by most participants as fundamental in coping with the effects of PTSD.

The provision of sufficient integrated family counseling and life skills programmes by the SAPS organisation was identified as crucial by most families in coping with the effects of living with a member diagnosed with PTSD.

## **KEY CONCEPTS**

Post-traumatic stress disorder; guideline; management; South Africa, police service workers

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### *Dedication*

*To my late father, Enos Ngoepe and to my mother, Sarah Ngoepe for providing me with the foundation of education.*

*To families giving mutual support to the SAPS workers to help manage Post- traumatic stress disorder.*

*In memory of two police workers who died on 2012-08-15, during the Marikana tragedy in the North West Province.*

*In memory of the SAPS worker who took part in this study and later died on 01 July 2012.*

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## CHAPTER 8

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## LIST OF ACRONYMS

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ANC</b>	African National Congress
<b>APA</b>	American Psychiatric Association
<b>ASD</b>	Acute Stress Disorder
<b>ATM</b>	Automated Teller Machine
<b>BMI</b>	Body Mass Index
<b>BRIG</b>	Brigadier
<b>CAPT</b>	Captain
<b>COL</b>	Colonel
<b>COPE</b>	Care of Pressurised Employees
<b>CISD</b>	Critical Incident Stress Debriefing
<b>CIC</b>	Crime Information Collection
<b>CIO</b>	Crime Intelligence Office
<b>COIDA</b>	Compensation for Occupational Injuries and Diseases Act
<b>CBT</b>	Cognitive Behavioural Therapy
<b>CFR</b>	Central Firearms Registry
<b>CONST</b>	Constable
<b>CRC</b>	Crime Records Center
<b>CRIMSA</b>	Criminological and Victimological Society of Southern Africa
<b>CISR</b>	Critical Incident Stress Reactions
<b>CSVR</b>	Centre for the study of Violence and Reconciliation
<b>CRI</b>	Coping Resources Inventory
<b>DoL</b>	Department of Labour
<b>DSM- IV</b>	Diagnostic and Statistical Manual Fourth Revision
<b>DSM-IV-TR</b>	An updated version of the DSM-IV
<b>EAP</b>	Employee Assistance Programme
<b>EHW</b>	Employee Health & Wellness
<b>EMDR</b>	Eye Movement Desensitisation and Reprocessing
<b>EMW</b>	Emergency Medical Worker
<b>FCS</b>	Family Violence, Child Protection and Sexual Offences
<b>GEN</b>	General
<b>GP</b>	General Practitioner
<b>HIV</b>	Human Immunodeficiency Virus
<b>HSREC</b>	Health Studies Research Ethics Committee
<b>HRM</b>	Human Resource Management
<b>ICD-10</b>	International Classification of Diseases-10 <sup>th</sup> revision

ICP	International Congress of Psychology
IDI's	In-depth Interviews
IPID	Independent Police Investigative Directorate
IPT	Independent Projects Trust
ISS	Institute for Security Studies
ISU	Internal Stability Unit
KPA	Key Performance Area
KZN	KwaZulu-Natal
LT	Lieutenant
LT. COL	Lieutenant Colonel
LT. GEN	Lieutenant General
MAJ	Major
MDD	Major Depressive Disorder
MIC	Management and Information Centre
MPS	Municipal Police Services
MVAs	Motor Vehicle Accidents
NGO	Non-Governmental Organisation
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
NIU	National Intervention Unit
OCD	Obsessive Compulsive Disorders
PFA	Psychological First Aid
PILIR	Policy and procedure on Incapacity Leave and Ill Health Retirement
PSA	Public Service Act
PTSD	Post Traumatic Stress Disorder
PTS	Post Traumatic Stress
PTSS	Post Traumatic Stress Symptoms
POLMED	Police Medical Aid Scheme
SADAG	South African Depression and Anxiety Group
SALC	South African Law Commission
SASF	South African Security Forces
SASH	South African Stress and Health
SASCI	South African Statistics & Crime Information
SAPA	South African Press Association
SAPS	South African Police Service
SAPU	South African Police Union
SA	South Africa
SGT	Sergeant

<b>SO</b>	Standing Order
<b>SPSS</b>	Statistical Package for the Social Sciences
<b>STF</b>	Special Task Force
<b>UN</b>	United Nations
<b>UNISA</b>	University of South Africa
<b>USA</b>	United States of America
<b>US</b>	United States
<b>VIP</b>	Very Important Person
<b>VIS</b>	Vehicle Identification Services
<b>WHO</b>	World Health Organization
<b>WTM</b>	Wits Trauma Model

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# **CHAPTER 1**

## **ORIENTATION TO THE STUDY**

### **1.1 INTRODUCTION**

Literature has revealed that the nature of work performed by police service workers is risky and extremely demanding (Van den Heever 2013:3; Rothmann 2008:11; De Bruin 2008:8; Pienaar & Rothmann 2006:72; Stromnes 1991:1; Chabalala 2005:1; Botha, Watson, Clark-Miller & Brady 2012:1; Volschenk & Van Zyl 2001:1). Globally, the nature of police service work involves exposure to traumatic incidents and accidents of various magnitudes, in the workplace and the South African police service workers (SAPS) are no exception. Police service workers experience and witness traumatic incidents on a daily basis during the execution of their duties. Examples of police service work include attending to gruesome vehicle accidents, interfacing with perpetrators and victims of crime and violence, witnessing various acts of community violence and the risk of being assaulted while on duty (Van den Heever 2013:3). Significantly, occupational exposures to such stressful and traumatic situations could increase the risk of developing vicarious trauma among the police service workers (Gumani 2012:45; Kgalema 2002:1).

According to Pearlman and Mac Ian (1995:558), Stromnes (1991:3) and Maabela (2011:2), if not appropriately managed, the effects of vicarious trauma on the SAPS workers could lead to the development of psychiatric health conditions, including anxiety disorders such as depression, major depressive disorders (MDD), acute stress disorders (ASD) and subsequently post-traumatic stress disorder (PTSD). Consequently, psychological harm arising from exposure to traumatic events will impact heavily on the SAPS workers' normal ways of thinking, feelings and compromise their usual ways of dealing with stressful circumstances (Matsakis 1998:17).

This chapter introduces the study and provides an overview of the entire thesis. The chapter begins with a description of the background information and is followed by the research problem, the aim, study objectives, significance of the study, as well as definitions of key concepts used in the current study. It further highlights the theoretical



framework used to underpin the study, the research design and method used, and the scope of the study. The chapter concludes with a description of a brief outline regarding data that will be presented in various chapters of this thesis.

## **1.2 BACKGROUND INFORMATION**

Post-traumatic stress disorder (PTSD) is an anxiety disorder which affects an individual's memory, emotional responses, intellectual processes and nervous system as a result of exposure to or witnessing one or more traumatic experiences (Ingersoll 2011:1; Khouzam 2013:578). PTSD is often regarded as "a normal reaction to exposure to or witnessing abnormal events" (Frey 2003:3; Ingersoll 2011:1). Exposure to traumatic experiences and events such as natural or man-made disasters, i.e. violent personal attacks, military combat, gruesome motor vehicle accidents, witnessing violent deaths, being a victim of torture, terrorist attacks, rape or sexual abuse, may cause PTSD (Khouzam 2013:578).

PTSD may begin soon after the stressful event or after an interval (delayed) usually of days, but occasionally for months, though rarely more than six months (Gelder, Gath, Mayou & Cowen 1996:10). Symptoms of PTSD may include persistent distress, nightmares, constant fear, anxiety and avoiding places where trauma took place. These symptoms may vary in cases of re-traumatisation and can either be less or more severe. According to Gelder et al (1996:10), most of PTSD cases resolve within about three months but some may persist for years depending on the kind of treatment taken, the victim's reaction to treatment, available support networks and other effective strategies put in place to manage the condition. According to De Jong, Kompore, Spinazzol, Van Der Kolk and Van Ommeren (2005:39), ineffective management of PTSD may lead to complex forms of PTSD which involve not only persistent fear and anxiety, but also core problems with relatedness and self-regulation of emotion, consciousness and bodily health that are described as "complex PTSD" or disorders of extreme stress.

### **1.2.1 Causal factors for PTSD**

Literature has revealed that the most important causal factor for PTSD is the severity of the traumatic event rather than the traumatic event itself (Van Zyl, Oosthuizen & Seedat

2008:119). Individual differences in the cognitive intensity, emotional make-up, level of resilience and individual responses to trauma determine the effect that trauma has on people, thus, two people exposed to traumatic events of the same intensity react differently; one may develop PTSD while the other may not (Gonzalez-Prendes & Resko 2011:17; Martin 2005:11; Macritchie 2006:10; Ahmed 2007:370). Furthermore, it is evident from global literature that individuals with a history of depression have an increased risk and vulnerability of developing PTSD after experiencing a traumatic event (Olley, Zeier, Seedat & Stein 2005:553; Centre for PTSD 2011:1; Martin 2005:11).

### **1.2.2 Traumatic incidents related to PTSD development**

The SAPS workers are operating within South African communities that experience high levels of violence and this exposes them to constant trauma which places them at risk for PTSD development (Macritchie 2006:13; Terblanche 2007:89). Such community violence include frequent car hijackings, house robberies, Automated Teller Machine (ATM) bombings, bank robberies, beatings, killings, rape, suicides and homicides (Terblanche 2007:89). These incidents are what the SAPS workers have to contend with on a daily basis in their attempts at bringing harmony and justice to the victims of perpetrated crimes in the country (Viljoen 2001:50).

The nature of police work makes it impossible to prevent workers from trauma exposure and its effects, thus trauma forms part of their daily work. As a result, workers are prone to developing secondary trauma, fatigue, withdrawal from friends and family members, loss of interest in hobbies, work-related accidents due to poor concentration, lack of physical and mental energy, and PTSD due to the nature of their work (Macritchie 2006:29; Richardson 2001:6; McCann & Pearlman 1990:133).

According to Viljoen (2001:49), police service workers' traumatic experiences can have tragic consequences for their personal, physical, social and psychological wellbeing. Many factors such as socio-political change, changes in public expectations, public criticism, police killings and negative media reports have an immense effect on the SAPS workers and those close to them. These result in both primary and secondary stress, and eventually develop into PTSD (Burke 2013:4; Meiring 1999:254).

*The Pretoria Newspaper* (2011, May 10), commented that South Africa is viewed as an extremely stressed society. The socio-economic and political turmoil of the past three decades and current high rates of violent crimes in the country impact negatively on ordinary South Africans and in particular, the SAPS workers (Louw & Viviers 2010:1; Chabalala 2005:4; Piennar & Rothman 2006:72). Violent crimes are occupational exposures for the SAPS workers, and are often traumatic and stressful. Media reports highlighted in *The Pretoria Newspaper* (2011, May 10) reflect the stressful nature of police service work. The reports outline that the SAPS workers were being accused of violently handling and interacting with community members and suspects of crime. This means that the SAPS workers have to contend with both socio economic stressors and the unique, physically and psychologically demanding police service work at the same time.

The South African Correctional services' workers, comparable to the SAPS workers, also experience occupational trauma and PTSD (Mostert 2001:1). Thus, work-related trauma is inevitable among these two professions falling under South African security forces. Correctional services work is viewed as a high-risk profession due to its nature, which exposes employees to violence and life threatening situations such as detainee escapes and other stressors that characterises the work. These factors contribute to occupational stress and the possible development of PTSD among correctional officers (Mostert 2001:1).

Within the South African Department of Health, Kriek (2008:7) conducted a study among Emergency Medical Workers (EMWs) in an effort to determine how they cope with the trauma and pressures associated with their occupation. The work-related traumatic incidents identified included exposure to continued physical trauma and tragedy, multiple patient casualties, violence, mutilation, human pain, suffering, dying, emotional stress – especially due to death of a child or colleague, and horror (Kriek 2008:27).

Various studies by Leino, Selin, Summala and Virtanen (2011:400), Muller-Burke, Attridge and Fass (1999:7) and Kris (2004:1) have revealed that occupations such as police service work, working as firefighters, emergency medical workers, technical and security officers and in the fields of banking, gold mining, aircraft and health industries, are regarded as high risk and stressful occupations which have a potential to expose

workers to continuous violence and trauma and to high risk of developing PTSD. Therefore, it is crucial to be aware of and have effective occupational health and wellness support programmes within these critical and high risk professions in order to curb the development of physical and mental health conditions and to primarily manage cases of PTSD and the effects thereof. The development of guidelines for PTSD management within the SAPS organization is fundamental.

### **1.3 THE RESEARCH PROBLEM**

#### **1.3.1 Source of and background to the problem**

##### ***1.3.1.1 Source of the research problem***

The SAPS workers' mental health report obtained from the local referring specialist psychiatrist for 2012 showed that an estimated 70-90% of the SAPS workers in the Mahikeng area were diagnosed with depression, MDD and PTSD (External Resource Referral Register 2012:1). The workers concerned were referred to onsite Employee Health and Wellness (EHW) professionals for further assistance, management and support. The researcher's attention was drawn by the increasing number of the SAPS workers who were referred by specialist psychiatrists to the onsite EHW practitioners for work-place and family counseling and support after being diagnosed with PTSD.

These mental health disorders are highly likely to be worsened due to the risky nature of police work which poses a threat on the health and wellness of the workers and consequently on their immediate family members' wellbeing due to living with a member diagnosed with PTSD. Therefore, the researcher identified the need to conduct a study in this area to enable development of guidelines to assist the Mahikeng SAPS organisation to render necessary care and support to workers diagnosed with PTSD and to their immediate family members.

Although the researcher's initial interest was to develop an intervention model for the management of PTSD among the SAPS workers, a specific need was identified to develop guidelines to manage PTSD among both the SAPS workers, and their immediate family members as they are directly affected by living with a member diagnosed with PTSD. The guidelines were developed in corporation of the WITS

Trauma Model (WTM) which was used as a framework for the current study as presented in detail in chapter 3 of the current study. The WTM was identified as suitable to address the needs of both groups of study participants. Therefore, the initially approved title for the current study is “An intervention model for management of PTSD among the SAPS workers in Mafikeng, North West Province; however the current study is the “Guidelines for management of PTSD among the SAPS workers in Mahikeng, North West Province of South Africa”.

### ***1.3.1.2 Background to the research problem***

The South African government has mandated the SAPS workers with the task of preventing crime within the country. The SAPS workers have thus been appointed to fulfill what Chabalala (2005:4) and Laguna, Linn, Ward and Ruplaukyte (2009:99) referred to as the role of creating a barrier between society and violence, ensuring order and establishing an environment of safety and security for all citizens. The carrying out of this task brings about observable challenges manifesting themselves in different forms of occupational stress, hence, stress is an inevitable part of police work (Bano 2011:290; Kloppe 2003:1; Omar 2008:1; Peltzer 2001:52).

According to Olivier (2009:4), exposure to trauma is inherent in police work, and about one third of police officers exposed to work-related traumatic incidents develop significant post-traumatic symptoms. South African police work is seen and experienced as one of the “most stressful” area of work in the country (Chabalala 2005:1; Gabarino, Magnavita, Elovainio, Heponiemi, Ciprani & Cuomo 2011:395; Young 2005:2; Louw & Vaviers 2010:1; Pienaar 2005:58; Leino, Selin, Summala & Virtanen 2011:401). Law enforcement is an emotionally and physically dangerous job (Young 2005:2). According to Olivier (2009:43), the latter statement is particularly true to the South African context given the very high levels of crime and violence in the country.

The most stressful nature of police work has an immense negative impact on the health and wellbeing of especially the SAPS workers who are directly exposed to trauma. This situation was presented as a major concern by the Minister of police, who highlighted an alarmingly high rate of national statistical data on police depression and PTSD, during the opening of the new Police Medical Aid Scheme (POLMED) house in Pretoria in

June 2012. The report indicated that more than 10 636 SAPS workers were suffering from depression and that 2 763 members were suffering from PTSD (Seanego 2012:1).

Emsley, Seedat and Stein (2003:237) investigated PTSD among 124 South African Security Forces (SASF) members who had been medically retired. The authors revealed that there was a long duration of exposure to work-related incidents ( $16.9 \pm 7.0$  years) that preceded the commencement of substantial signs of PTSD amongst the population studied. The majority, (90%) of the SASF members displayed a negative attitude toward their work. About 54% of them believed that issues related to the transformation of the services played a significant role in the stirring of the disorder. As a result of the long-lasting civil conflict in the country, many workers of the SASF were exposed, for many years, to remarkably high levels of violence and turmoil during the course of their duties. Therefore, they would be expected to be at a high risk for emergent PTSD (Emsley et al 2003:237).

Furthermore, a study conducted in the Johannesburg area found that 49% of active workers of the Internal Stability Unit (ISU) of the SAPS organisation met norms for PTSD (Kopel & Friedman 1997:309). However, regardless of prolonged exposure to trauma, it is only recently that the number of SASF workers who retired on psychiatric grounds has increased considerably. An alarming increase in applications for retirement on medical grounds for members of the security forces in South Africa has indeed been observed in recent years (Mokoka, Rataemane & Dos Santos 2012:34; Emsley & Coetzer 1996:1). Prominently, between 1991 and 1999, the number of police workers who retired on psychiatric grounds increased from 37 per year to 729 per year (Kopel et al 1997:309).

PTSD is often exacerbated by an underlying depression and in most cases the symptoms of both PTSD and depression interconnect to an extent that occasionally it becomes difficult to distinguish between the two (Stromnes 1991:8). A study by North, Smith and Spitznagel (1994:51) found that depression and MDD are a frequent post-trauma diagnosis symptom among trauma survivors, followed by PTSD. Focusing on survivors of a mass shooting, North et al (1994:51) observed that MDD was present in 35% of women and 25% of men. Another finding from an American survey conducted by North, Nixon, Shariat, Mallonee and Mc Millen (1999:755) showed that 23% of the survivors from the Oklahoma City bombing of 19 April 1995 presented with depression

after the bombing, paralleled to the 13% with depression prior to the bombing. The study suggested that PTSD and depression often harmonise. The results indicated further that depression is nearly 3 to 5 times more likely in those with PTSD than in those without PTSD.

Nevertheless, an increasing number of the SAPS members diagnosed with MDD and PTSD in the Mahikeng cluster area was a great concern for the researcher. This also seems to be a concern for the former and the current SAPS National Commissioner as well as the Minister of the SAPS organisation who raised their concerns in the press about the high stress levels suffered by the members of the SAPS (*The Pretoria Newspaper* 2011, May 10; Seanego 2012:1). The newspaper article entitled “*Cops stress level- time bomb*,” highlighted the magnitude of psychological ill health among the SAPS workforce (Hosken 2011:1), which further warranted the need to conduct this study.

#### **1.4 RESEARCH PROBLEM**

South African police workers are placed under enormous stress by the kind of work they engage in on daily basis (Louw et al 2010:1; Van den Heever 2013:10; Stromnes 1999:72; Marks 1995:1; Violanti 2008:2; Chabalala 2005:4). As a former SAPS EHW practitioner, the researcher has experienced and witnessed the dangerous nature of police work and observed as well as learned that operational police officials deal with life and death on a daily basis. The SAPS workers must therefore be willing to put their lives at risk or harm while performing their policing duties (Stromnes 1999:72).

Research studies conducted locally and internationally suggest that the nature of police work in both local and international environments is highly stressful. These include studies by Garbarino et al (2011:395) and Steyn, Vawda, Wyatt, Williams and Madu (2013:20) which showed that there is an increased rate of post-traumatic stress, burnout, alcohol abuse as well as decreased levels of job satisfaction and job performance within the police force in comparison to the norms of the general population. Thus, police members are more susceptible and at risk of developing PTSD (Young 2005:58).

Garbarino et al (2011:395) cited a study on the Swiss police that outlines organisational and operational stressors, which include high mental and intellectual demand, inadequate work schedule, and lack of senior management support, self-perception of poor quality work, physical environment and age. In addition, according to Leino et al (2011:400), most police officers find it difficult to withdraw from their challenging work even if they feel extremely threatened because of their commitment to duty and upholding law and order in society. Therefore, the immense physical, intellectual and psychological demands, exposure to traumatic incidents and interaction with violent subjects serve as occupational stressors for police workers (Garbarino et al 2011:395; Steyn et al 2013:20).

The researcher's awareness of the increasing number of PTSD cases among the Mahikeng SAPS workers and the effect this had on their wellbeing and on their immediate family members suggested the high magnitude of the problem of PTSD, and thus called for its management through the use of scientifically developed and approved guidelines. It is also the researcher's professional responsibility to conduct research in her field of specialisation to address identified aspects of concern, and come up with recommendations on ways of effectively addressing the concerns, with the aim of ensuring good health and wellness within the SAPS organisation.

## **1.5 AIM OF THE STUDY**

The aim of this study was to develop guidelines to assist the SAPS organisation to provide appropriate interventions for workers diagnosed with work and non-work-related PTSD in the Mahikeng area. Furthermore, it aims to assist the workers' immediate family members to cope with living with a member diagnosed with PTSD. The guidelines will also provide the SAPS Human Resource Management (HRM) office with information to assist in rendering activities appropriate in promoting the occupational wellbeing of workers diagnosed with PTSD in terms of job placement and ill health processes. It is also expected that the guidelines will help in providing such staff with professional support and accommodating their needs with regards to service delivery.



### **1.5.1 Research objectives**

The objectives of this study were to:

- Determine the life-time prevalence of PTSD among the SAPS workers in Mahikeng, North-West province.
- Describe the socio-demographic characteristics of the SAPS workers diagnosed with PTSD and their family members in Mahikeng, North-West province.
- Identify and describe work and non-work-related traumatic incidents for possible PTSD development among the SAPS workers in Mahikeng, North-West province.
- Ascertain the health and social effects of PTSD among the affected SAPS workers and their immediate family members and their coping mechanisms.
- Identify the available onsite occupational health and support services provided to the affected SAPS workers and immediate family members to deal with PTSD in the study area.
- Explore the affected SAPS workers and family members' opinions and recommendations for PTSD management.

### **1.6 SIGNIFICANCE OF THE STUDY**

It is envisaged that the findings of this study will lead to the development of guidelines that will promote effective management of PTSD among the SAPS workers in the Mahikeng area. In addition, the implementation of the proposed guidelines will contribute towards the reduction of reported cases of PTSD within the SAPS organisation, and bring about an element of support and sense of "being cared for" by the SAPS organisation among the SAPS workers diagnosed with PTSD.

Furthermore, policy makers within the SAPS organisation will be guided by the guidelines developed in this study in formulating inclusive and supportive human resource management and occupational health and wellness policies and programmes. The guidelines will assist in developing pro-active policies and ensuring more supportive reactive ones for effective management of PTSD. The study will also add value to the existing data and literature on trauma and PTSD within the SAPS organisation and highlight the importance of filling gaps on important areas requiring attention.

## **1.7 DEFINITION OF KEY CONCEPTS**

### **1.7.1 Post-traumatic stress disorder**

It is an anxiety disorder following an exposure to an extreme traumatic event. The event is outside the individual's normal realm of experience and overwhelms their usual psychological defenses (Circular instruction 172 – PTSD 2002:4). In this study, PTSD refers to a psychological disorder developing after exposure to work and non- work-related trauma among the SAPS workers in Mahikeng.

### **1.7.2 Traumatic incident**

The Center for Disease Control and Prevention (2011:5) defines a traumatic incident as any event that has significant emotional power to overwhelm usual coping methods. It involves any situation or event faced by emergency or public safety personnel that causes a distressing, dramatic or profound change or disruption in their physical and/or psychological functioning (The Center for Disease Control and Prevention 2011:5). In this study a traumatic incident refers to incidents which police officials get exposed to as they carry out their operational policing duties and attend to incidents which have a negative psychological effect. Traumatic incidences are those incidences that impact negatively on the police officials' usual ability to cope with general life and work demands.

### **1.7.3 Trauma**

On the psychological level, trauma refers to severe damage to an individual or society's emotions, one's will to live, their beliefs about themselves and the world, their dignity and sense of security (Ford 2009:6; Matsakis 1998:17). In this study, trauma means exposure to incidents that impact negatively on the SAPS workers' normal functioning and coping ability.

### **1.7.4 Debriefing**

Debriefing means emotional ventilation of feelings in a controlled and safe environment, after exposure to trauma (Botha et al 2001:3). In this study, debriefing means a process

of creating an enabling, conducive environment to express thoughts and feelings related to a traumatic incident that police officials were exposed to and providing educational coping mechanisms to manage the traumatic reactions; this is done by a trained trauma debriefer.

#### **1.7.5 Guideline**

The Oxford Concise Dictionary (2010:518) defines a guideline as a principle or criterion guiding or directing action. In this study, a guideline is a set of suggested rules or instructions that an organisation, in this case the SAPS, can use to facilitate and enhance the occupational and family support network and systems to workers diagnosed with work-related PTSD and their immediate family members.

#### **1.7.6 Support system**

This is a network of personal and professional contacts available to a person or an organisation providing practical or moral support, when needed, for the necessities of life (The Collins Dictionary 2008:1670; Thesaurus online-Dictionary 2012:1). In this study a support system refers to a variety of people and institutions that the SAPS workers have and use for moral and practical support. This may include immediate and extended family members, professional people such as medical doctors, psychologists, specialist psychiatrists, and the SAPS EHW professionals (police chaplains, psychologists, social workers and psychometrists).

The support system may also include colleagues, supervisors, local church priests, neighbors and other community members whom the SAPS workers are close to and regard as confidantes. It is to these personal and professional contacts that the SAPS workers are able to openly ventilate the challenges experienced in their personal, family, work, health and social lives and get assistance on how to manage such challenges after interacting and consulting with support networks.

#### **1.7.7 Workers**

The word worker refers to someone who works in a particular job or is employed to work with their own hands rather than to organise (The Cambridge International Dictionary

2002:1679). In the context of this study, workers refer to people employed by the SAPS organization. The SAPS workers are appointed under either the SAPS Act or the Public Service Act (PSA).

#### **1.7.8 Cluster**

According to the Oxford Concise Dictionary (2010:219), a cluster is a closely-packed group of people or things. In this study the term cluster denotes a group of police stations and units located in the vicinity of Mahikeng.

### **1.8 CONCEPTUAL FRAMEWORK**

The conceptual framework used for this study is the Wits Trauma Model (WTM). The WTM recognises that trauma impacts on both internal and external psychological functioning, and thus requires a treatment approach which addresses both internal, psychodynamic processes, as well as intervention which is structured and problem oriented (Hajjiyannis & Robertson 1999:4).

The WTM is deemed suitable for this study as it was developed out of an amalgam of conceptually informed approaches and clinical experience in treating traumatic stress conditions, specifically in the South African context (Bean 2008:22).

### **1.9 RESEARCH DESIGN AND METHOD**

Lester (2005:21) defines research design as “an overall plan for collecting and analysing data”. A research method refers to the manner in which data is collected and analysed, and the instruments used to collect and analyse data (Melville & Goddard 1996:27).

#### **1.9.1 Research design**

A qualitative design was used in this study. This design was suitable to solicit data from the study participants as the study variables were mainly qualitative in nature.

## **1.9.2 Sampling**

Purposeful sampling was adopted in the study, thus the study focused specifically on the workers who have been diagnosed with PTSD and on family members affected by living with a member diagnosed with PTSD.

### **1.9.2.1 Sample size**

The size of the study participants comprised of 19 police workers diagnosed with PTSD and 23 immediate family members.

## **1.9.3 Study setting**

The study was conducted in the SAPS police stations and units located in the Mahikeng cluster area of the North West province. All the stations and units from which data was collected are located within the vicinity of Mahikeng. The police stations included the following: Mahikeng, Mmabatho, Lomanyaneng, Makgobistad, Mooifontein, Ottoshoop and Tshidilamolomo. The specialised units were the Management and Information Centre (MIC), Vehicle Identification Services (VIS), Family Violence, Child Protection and Sexual Offences (FCS), Stock theft, Crime Intelligence Office (CIO), Flying Squad (also called 10111/Highway patrol), Inspectorate, Legal Services, Organized Crime, and Commercial Branch.

## **1.9.4 Study population**

The target population for this study comprised of the SAPS workers diagnosed with PTSD and their immediate family members such as spouses, dependents aged from 18 years and above, parents and siblings in some cases.

## **1.9.5 Data collection procedure**

An unstructured questionnaire was used to conduct in-depth interviews to collect data from the SAPS workers diagnosed with PTSD and their immediate family members. The data collection instrument was unstructured as it consisted mainly of open ended

questions, which enabled the researcher to solicit more information from the study subjects.

#### **1.9.6 Data analysis**

Data was analyzed using Microsoft Excel programme to group together themes which were discussed qualitatively. Biographical data and other data from closed ended questions was analysed using the Statistical Package for the Social Sciences (SPSS) version 20.0.1 as well as. The results of the analysed data are presented using tables and brief statistics.

#### **1.10 SCOPE OF THE STUDY**

This study was conducted among the SAPS workers diagnosed with PTSD and among their immediate family members in the Mahikeng cluster area police stations and units located in the North West province of South Africa. The study investigated a wide range of aspects relating to PTSD such as how the disorder affects the workers and their immediate families' health, and social settings.

Furthermore, the available occupational health interventions and programmes offered to the Mahikeng SAPS workforce and to their immediate family members to assist them manage PTSD were also explored by the study. The aim was to develop proposed guidelines to manage PTSD among the SAPS workers and immediate family members in Mahikeng, North-West province.

#### **1.11 STRUCTURE OF THE THESIS**

This thesis is presented in seven chapters. They are described as follows:

##### **Chapter 1: Orientation of the study**

The chapter gives an overview of the entire study. It discusses the study background, the research problem, study objectives, the aim, significance, definition of key concepts used in the study, the foundation of the study, the research design and method used, the scope and the thesis layout.

## **Chapter 2: Literature review**

This chapter focuses on a wide range of issues pertaining to PTSD and its effect on the SAPS workers, family members and on the SAPS organisation. Literature on work and non-work stressors, local and international PTSD prevalence and management is also reviewed. The chapter outlines the intervention programmes available within the SAPS organisation to manage PTSD.

## **Chapter 3: Conceptual framework**

This chapter discusses the conceptual framework that guided the study. It also explains the key components of the Wits Trauma Model and its effectiveness in managing trauma and PTSD in the South African context.

## **Chapter 4: Research design and methods**

This chapter focuses on the research methodology and approach used in this study. The chapter highlights the design, study population, the instruments used to collect data, and aspects relating to validity, trustworthiness, reliability, data analysis and ethical considerations.

## **Chapter 5: Data analysis, presentation and description of research findings**

The focus of this chapter is on the analysis of data gathered from study participants. The analyses include the description and presentation of the findings.

## **Chapter 6: Discussion on research findings**

The chapter discusses findings from both groups of participants; namely the SAPS workers and their immediate family members, basing on the results presented in chapter 5.

## **Chapter 7: Conclusions and recommendations**

In this chapter, the focus is on the discussion of study findings that emerged from chapter 5. It also gives a set of recommendations on how PTSD could be managed in the SAPS organization and among the immediate family members of the workers in the; Mahikeng cluster area in the North West province of South Africa.

## **Chapter 8: Guidelines for the management of PTSD among the SAPS workers in Mahikeng, North West province of South Africa**

The chapter gives a presentation of guidelines developed for the management of PTSD in the Mahikeng cluster area, North West province of South Africa.

### **1.12 CONCLUSION**

This chapter gave an overview of the study on the management of PTSD among the SAPS workers and their immediate family members in Mahikeng, situated in the North West Province of South Africa. The chapter outlined a general background of trauma and PTSD within the SAPS organisation, and discussed the study purpose as well as the methodology used in the current study. The chapter further described the conceptual framework around which the study revolved. The legislation related to trauma and PTSD, in the context of the SAPS organisation, was also outlined in this chapter.

The next chapter reviews the literature that relates to the focus of this study.



## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

In this chapter, the researcher reviewed literature on trauma and PTSD. Its subsections discuss various causes of PTSD and the general and individual risk factors that increase vulnerability to the development of PTSD. The chapter also focuses on specific police work and non-work related risk factors, and the effects of PTSD on work, family and social lives of police workers, as well as the various coping mechanisms used by police service workers to deal with PTSD.

Lastly, the chapter highlights the management of PTSD among police service workers in South Africa, with a specific focus on primary, secondary and tertiary levels of prevention.

#### **2.2 DEFINITION OF POST TRAUMATIC STRESS DISORDER (PTSD)**

According to the Department of Labour's Circular Instruction No. 172 (DoL 2002:4), PTSD is a mental disorder following exposure to an extreme, unexpected, sudden and non-routine traumatic event or stressor. The traumatic event would be outside the individual's normal sphere of experience and overwhelms the individual's psychological defenses (Circular Instruction No. 172 2002:4)

#### **2.3 EVIDENCE OF TRAUMATIC INCIDENTS LEADING TO PTSD AMONG POLICE SERVICE WORKERS**

Local literature on trauma posited that high rates of various traumatic events cause PTSD among South Africa's police service workers. The events include criminal violence, motor vehicle accidents (MVAs) and industrial accidents (Macritchie 2006:8; Edwards 2005:209). Such events often include experiencing or witnessing a gruesome incident or experiencing gross physical injury, receiving a life-threatening medical diagnosis, or being the victim of kidnapping or torture (De Beer 2013:1; Pfeifer 2011:8; Van den Heever 2013:1; Clark-Miller et al 2012:1; Perry 2003:9; Madu & Poodhun 2006:213; Matsakis 1996:17).

Various local and international studies have indicated that the exposure to war combat; disasters such as plane crashes and terrorist attacks; encountering and sometimes being the victim of rape, mugging, robbery or assault; and involvement in civil conflicts during service delivery protests, as part of police work, is stressful and a constant suppression of the related trauma may lead to PTSD diagnosis, as the stress takes its toll slowly or quicker, leading to PTSD (Madu et al 2006:216; Ahmed 2007:369; Rosen & Frueh 2011:36; Omar 2008:3; Young, Koortzen & Oosthuizen 2012:4; Wiese Rothman & Storm 2003:72; Anderson 2013:1; Grinage 2003:2403; Tehrani 2004:7; Ford 2009:11; Tehrani 2011:65; Roberts 2002:2).

The types of traumatic events that the police workers in the study site got exposed to during the period of 2013 to 2014 include motor vehicle accidents, shooting incidents and deaths of colleagues (The SAPS National trauma report 2014:1).

## **2.4 WORK-RELATED RISK FACTORS LINKED TO THE DEVELOPMENT OF PTSD**

### **2.4.1 Local and international perspectives**

Work-related trauma includes mechanical, biological, biomechanical, chemical and radiological activities as well as those aspects of work design, the social and environmental contexts of an organisation and work management that have the potential of causing psychological, social or physical harm (Van den Heever 2013:5; Du Plessis 2007:2; Omar 2008:2; Joubert & Grobler 2013:1; Pienaar & Rothman 2008:1).

Exposure to traumatic incidents at work places results in a lot of stress on law enforcement personnel and emergency rescue personnel. The stress serves as a major workplace health and safety hazard (Chabalala 2005:1; Van Lelyveld 2008:2; Edwards 2005:131; Kopel et al 1997:307; Clark-Miller et al 2012:1; De Beer 2012:1; Myendeki 2008:2; Pietrantonio & Prati 2008:1; Du Plessis 2012:1). Chabalala (2005:1) concurred with Young (2003:1) in acknowledging the existence of occupational stress in all work situations and noted further that the high life threatening nature of the law enforcement environment places exceptionally high performance expectations on police workers.

Pienaar and Rothman (2006:73) conducted a study using stratified random sampling among 2 145 police workers in nine provinces of South Africa. They identified the use of force, exposure to danger, facing the unknown and shift work as work-related risk factors that may lead to PTSD (Pienaar et al 2006:73). Within the SAPS organisation:

Mahikeng, the workers equally face the same situation of constant contact with trauma and confronting the unknown mainly due to the unpredictable nature of police work.

#### **2.4.2 Workplace hostility**

Hostility is a risk factor for PTSD within the SAPS workforce, especially as the police workers contend with perpetrators of crime (Yoyo 2013:1). For example, police encountered hostilities during interventions in community clashes, community xenophobic attacks, physical and verbal assaults and killings reported in Alexander township during 1990, where 50 people got killed (Yoyo 2013:1). Furthermore, the city of Cape Town and the North West and Gauteng provinces experienced a tremendous increase in xenophobic attacks during the period 2010-2012, with 67 people dying from the attacks (Anderson 2013:1). These situations were hostile and traumatic to the SAPS workers.

#### **2.4.3 Exposure to civil hostilities**

Further workplace exposures to violent deaths and public hostilities were encountered by the SAPS workers in 2012 and 2013 (*The Star Newspaper*, 19 June 2013:4). During August 2012 and May 2013, police workers in the North West Province dealt with violent hostilities involving assaults and killings at the Marikana Lonmin Mine in Rustenburg; where miners were protesting over work-related issues (*The Star Newspaper*, 19 June 2013:4). In this study, some of the participants formed part of the Marikana massacre intervention team, thus they were also exposed to the violent hostilities experienced at Marikana.

#### **2.4.4 Exposure to lengthy periods of war**

Exposure to lengthy periods of harsh wartime conditions, leads to great difficulties in adjusting to civilian life, especially among veterans. This places the soldiers at high risk of PTSD development (Ahmed 2007:372; Yehuda 2002:108; Dryden-Edwards 2012:1). Furthermore, a report based on the interviews of the United States (US) soldiers conducted by specialist psychiatrists about the September 11 2001 terrorist attack of the World Trade Centre showed that the terrorist attack caused PTSD among the soldiers who survived and their family members. This concurs with findings by Schwartz (1999:2) that soldiers from various armies involved in armed conflict have developed PTSD. Psychiatrists also noted that civilian survivors and those who witnessed the deaths also suffered from PTSD (Dryden-Edwards 2012:1). Similarly, people who lose

relatives and friends during wartimes are at high risk of developing PTSD (Dryden-Edwards 2012:1; Yehuda 2002:108). In addition, refugees coming from regions exposed to prolonged conflict and victims of personal torture and incarceration due to losses in combat also have a high risk of developing PTSD (Ahmed 2007:371). These observations about the role of the effects of wartime and conflict trauma in the development of PTSD are also applicable to the South African conditions.

The SAPS workers have been involved in stressful combat for decades (Pienaar et al 2006:72). The SAPS organisation was, for example, involved in the country's transformation processes as peace keepers and in the dissolution of apartheid and the socio economic turmoil of the past 30 years (Pienaar et al 2006:72). This direct involvement in the difficult social and political transformation of the country led to personal stressors such as fear, anxiety, incompetence and self-doubt feelings among the SAPS workers (Pienaar et al 2006:72). In this study, some of the participants were also involved in the apartheid's "Hangpal" processes where they were directly taking part in the implementation of the process which involved direct assassination of detainees.

## **2.5 NON-WORK RELATED RISK FACTORS LEADING TO THE DEVELOPMENT OF PTSD**

### **2.5.1 Low scores on measures of intelligence**

People who have been found to have low Intelligence Quotient (IQ) levels, which normally lead to poor performance at school or work partly due to the effect of trauma on the memory, are vulnerable to PTSD development (Pfeifer 2011:11). According to DeNoon (2015:2), verbal skills linked to intelligence may protect people from the lasting effects of a terrible trauma. DeNoon (2015:2) cited a study conducted among Vietnam War Veterans, with and without PTSD, in which the veterans took a verbal intelligence test. The results of the study indicated that the veterans who did better on the IQ tests were less likely to have PTSD. Furthermore, the veterans who had PTSD, despite higher IQ, tended to have less severe PTSD symptoms (DeNoon 2015:2). The results of the study further suggested that veterans with higher intelligence may have been able to get more support as they were better able to verbalise and catharsis about their traumatic experiences, and thus decrease their vulnerability to the development of PTSD development and severity of PTSD symptoms on those who already had PTSD (DeNoon 2015:2).

### **2.5.2 Genetic risk factors**

According to Ahmed (2007:370) and Sherin et al (2011:5), ample evidence showed that vulnerability for PTSD is heavily influenced by genetic factors. For example, Ahmed (2007:370) cited findings from a study by Davidson, Swartz and Storck (1985) which suggested that trauma victims who develop PTSD are more likely, than those who do not, to have parents and first degree relatives with mood, anxiety and substance use disorders (Ahmed 2007:370). Ford (2009:74) and Ahmed (2007:370) cited a study on PTSD prevalence in monozygotic and dizygotic twins of Vietnam veterans conducted by True, Rice and Elsten (1993). The results showed that genetic factors accounted for approximately 33-34% of the risk of developing PTSD (Ford 2009:74; Ahmed 2007:370).

### **2.5.3 Age**

Responses to trauma are influenced by emotional, social and cognitive development of the individual at the time of exposure to trauma (Ford 2009:80). The author further posited that lower levels of development among children may function to protect them from experiencing an incident as traumatic. Thus, the younger the child, the more likely he or she is still developing critical psychological capacities which may be disrupted by exposure to trauma (Ford 2009:80).

On the other hand, adolescents exposed to trauma are more prone to developing PTSD as compared to latency age children (Ford 2009:80). Furthermore, PTSD symptoms in older adults, who suffered severe and prolonged trauma, such as the military combat veterans and those exposed to hurricanes, floods and earthquakes, were found to be less frequent and intense than those found in younger adults who had been exposed to comparable traumatic incidents. The difference emanated from the varying logistical and psychological emergency and disaster preparedness among the two groups, where older adults were found to have been more prepared than younger adults (Ford 2009:84).

### **2.5.4 Family history of psychological problems and psychiatric illnesses**

Psychological instabilities in families also contribute towards vulnerability to PTSD development (Ford 2009:75). Families who are constantly engaging in conflicts such as extensive domestic violence, abuse and extreme family disorganisation are highly vulnerable to PTSD (Ford 2009:75). Exposure to childhood trauma can be dangerous,

especially, if childhood trauma is not resolved. As a result, the fundamental sense of fear and helplessness carries over into adulthood, setting the stage for further trauma and other social and health problems such as drug abuse, anti-social behavior, and PTSD development (Perry 2003:2; Van den Heever 2013:1, Young 2005:74; Roberts et al 2011:72 and Ford 2009:75). Furthermore, the severity of exposure to traumatic stressors plays a fundamental role here. Thus, the more one is exposed to harm or threat, the greater the prospect that the exposed person will consequently suffer PTSD (Ford 2009:63).

Families with chronic and severe mood disorders such as major depression or bipolar disorder; anxiety disorders such as obsessive-compulsive, panic or generalised anxiety; and psychotic disorders such as schizophrenia, as well as eating disorders such as anorexia or bulimia nervosa, often report a history of exposure to psychological trauma as well as PTSD (Ford 2009:65).

### **2.5.5 Poor social support networks**

A study by Klaric, Franciskovic, Klaric, Kresic, Grkovic, Lisica and Stevanovic (2008:466) determined the correlation between social support and PTSD symptoms in women traumatised by war and postwar social insecurity in Herzegovina. The results indicated that social, emotional and physical support rendered by friends, family members and co-workers played a significant role in managing PTSD symptoms among participants. This shows that social support is one of the greatest resources in coping with trauma (Klaric et al 2008:466). Social support plays a healing role from traumatic experiences as the trauma survivor is made to feel that he or she is not alone and is cared for after the incident. Therefore, the lack of social support for victims of trauma exposes the victims to high risks of developing PTSD (Pfeifer 2011:19; Balenger 2010:2; Ford 2009:75; Beckam & Beckam 2009:7).

### **2.5.6 Gender**

According to Lynch (2007:6) and Ford (2009:73), women are more likely to report high levels of PTSD symptoms than men. This is due to the fact that women are more emotionally responsive and disclose emotions and health problems more easily than men (Lynch 2007:6). Irish, Fischer, Fallon, Spoonster and Sledjeski (2011:3) concurred with the latter findings by Lynch (2007) and Ford (2009), attributing this to gender differences in initial psychological and physiological responses to trauma. Findings by

Irish et al (2011:3) were based on a study among 356 adult MVA (males and female) survivors. The study aimed at examining a number of peri and initial post-traumatic reactions to motor vehicle accidents, to determine the extent to which they contributed to gender differences in Post-Traumatic Stress Symptoms (PTSS). The study concluded that initial responses to trauma may account for observed gender differences in PTSS development (Irish et al 2011:3).

### **2.5.7 Race/ethnic group**

A study by Roberts et al (2011:80) compared trauma exposure, risk for PTSD among those exposed to trauma and the treatment seeking patterns among whites, blacks, Hispanics and Asians in the US general population. The results indicated a high (8.7%) PTSD life-time prevalence rate among blacks and lowest (4.0%) among Asians (Roberts et al 2011:80). The differences in risk for trauma varied by type of event, but whites were more likely than other racial groups to have any trauma, to learn of a trauma of someone close and to learn of unexpected death, among those exposed to trauma, and PTSD risk was slightly higher among blacks (Roberts et al 2011:80).

Furthermore, all minority groups were less likely to seek treatment for PTSD than whites and fewer than half of the minorities with PTSD sought treatment. The study concluded that when PTSD affects the US minorities, it is usually untreated due to stigma attached to seeking professional help, reluctance to seek assistance outside family setting, mistrust of physicians, reduced access to general and mental health treatment facilities and services due to residence in poverty stricken areas and low socio-economic status (Roberts et al 2011:82).

### **2.5.8 Level of work experience**

High symptoms of work-related PTSD have been correlated with less work experience, especially with being young and new at work, particularly during the first four years of employment (Van Lelyveld 2008:12; Lynch 2007:18; Gumani 2012:85). In contrast, Turner (2011:3) evaluated the relationship between levels of training and work experience on self-efficacy and the effect of self-efficacy on the manifestation of PTSD symptoms among 127 firefighters. The study found no significant difference in the relationships between levels of training and self-efficacy or between years of work experience and self-efficacy. However Turner (2011:5) supported prior research that

indicated a statistical negative correlation between self-efficacy and symptoms of PTSD, thus when self-efficacy increased, the symptoms of PTSD decreased.

### **2.5.9 Individual factors contributing to vulnerability to developing PTSD**

According to Olivier (2009:55) and Wiese et al (2003:71), individual differences or vulnerabilities are significant on the way trauma impacts on an individual. This is because each individual constitutes a history that shaped their internal worlds, hence a unique and different individual character and personality. Individuals have their own culture, which contributes to how trauma will impact on them (Balenger 2012:2).

#### **2.5.10.1 Individual response to trauma**

There is need for an awareness of the different personality characteristics, including self-identity, world-view, level of individual spirituality, types and degrees of individual psychological needs, self-capacities, ego-resources and meanings that the individual person attributes to trauma (Gumani 2008:56). The manner and level of preparedness at which people come across traumatic events is also different. Different life experiences and personal histories all determine how one perceives and respond to trauma (Yuan et al 2010:45; Balenger 2010:2; Olivier 2009:56).

#### **2.5.10.2 A history of prior traumatization**

Police workers who experienced trauma in their child or adulthood and have not effectively dealt with it, may displace their reactions onto other people. For example, a police worker can be vengeful, very harsh on the perpetrators of crime or work tirelessly on a rape case to ensure that justice is done, especially in a case where their family member was raped, thus, keeping in mind their previous trauma (Iniedu 2011:3; Van Lelyveld 2008:12; Gumani 2012:83).

According to Gumani (2012:83), exposure to childhood trauma disturbs an individual's cognitive schemas and frame of reference. Therefore, as the individual grow up, the traumatic experiences are re-interpreted and reconstructed. This shows the importance of effectively dealing with childhood traumatic experiences to allow for effective management of adulthood traumatic experiences. Macritchie (2006:10), in concurrence underscored that the nature of trauma an individual police worker was exposed to and how it was managed is crucial for future trauma management. Various SAPS workers have been exposed to trauma in the past and continue to interface with perpetrators



and victims of crime on a daily basis. This increases their risk and vulnerability to develop vicarious trauma and subsequently PTSD (Young 2005; Iniedu 2011:3; Macritchie 2006:10).

#### ***2.5.10.3 Underdeveloped protective skills***

Skills such as self-esteem, creativity, self-efficacy, humor, discipline and problem-solving abilities need to be fully developed to reduce vulnerability to PTSD (Olivier 2009:56). People with more confidence in themselves are more likely to seek and receive social support and people with strong social support networks manage trauma effectively (Ford 2009:91).

According to Tehrani (2011:27), using ineffective coping mechanisms, such as repression, ignorance and avoidance of traumatic reactions, and substance abuse to deal with trauma and general life challenges by police workers may lead to the inability to thrive in the face of problems and trauma (Tehrani 2011:27). As a result, lack of crucial protective factors such as intelligence or education which act as protective factors that enable a person to access socio-economic resources such as information on where and how to obtain professional help, and financial affordability to pay for such services; may hamper effective trauma management (Ford 2009:90).

#### ***2.5.10.4 Individual biology and resilience***

Individuals react to and deal with trauma differently. This is reflected in situations where some people are able to maintain a state of normal equilibrium in the face of extremely unfavorable conditions and are able to rebound quickly even from most tragic and shocking experiences. On the contrary, other people may be devastated by experiences that may appear to be less upsetting to others (Ahmed 2007:372). Thus, individuals exposed to traumatic events respond in different ways (Sherin et al 2011:5; Yehuda 2002:110; Ford 2009:79). For example, most people may experience minimal (seconds) to brief (hours) to short term (days/weeks) abnormalities while a smaller number may suffer from significant pathology over longer-term (months) and chronic (lifetime) time frames (Sherin et al 2011:5). Olivier (2009:56) observed that some individuals tend to appear to have over reactive nervous systems, which poses them to high vulnerability to PTSD development by over reacting to even ordinary, less traumatizing events (Olivier 2009:56).

Factors such as cultural belief systems, attitudes, positive and effective coping strategies and psychosocial cohesion have been suggested as conveying adequate protection and endorsing resilience in the face of trauma. Furthermore, resilient individuals may show insight, initiative, humor, creativity and independence, the latter largely contributing positively to buffer against traumatic stress and its effects on them (Ahmed 2007:370; Ford 2009:77).

Pietrantonio et al (2008:1) conducted a study among 961 emergency rescue personnel as first responders at traumatic scenes with the aim of examining resilience factors protecting mental health among first responders. The results identified self-efficacy, believing in one's capabilities, self-worth, collective efficacy of working together as a team to manage traumatic encounters; and a sense of community being part of and belonging to a collective, as resilient factors that assist emergency rescuing personnel and first responders' work-related mental health. The study concluded that resilience, following critical events, is common among first responders (Pietrantonio et al 2008:1).

#### ***2.5.10.5 Specific individual personality characteristics and their contribution to the development and management of PTSD***

Various studies have shown that a majority of individuals who face potentially catastrophic trauma do not go on to develop PTSD (Jaksic, Brajkovic, Ivezic, Topic & Jakovljevic 2012:256; Ahmed 2007:370; Pillay 2008:17; Olivier 2009:56; SADAG 2009:1; Yuan, Wang, Inslicht, McCaslin, Metzler & Henn-Haase 2010:45; Sherin et al 2011:5; US NIMH 2005:1). Such individuals are considered to be resilient to PTSD development (Ahmed 2007:370). Thus, these individuals are able to maintain a state of normal equilibrium in the face of extremely unfavorable circumstances (Ahmed 2007:370).

Specific personality characteristics are at play in the development of PTSD (Yehuda 2002:110; Van Jaarsveld et al 2005:51). These include constant feelings of insecurity, lack of personal control and alienation from others. Such individuals are therefore more likely to experience higher levels of burnout, depression and PTSD subsequent to exposure to traumatic events (Cheryl, John & Graham 2000:335; Stander, Olson, Joshi, Mc Whorter & Merrill 2011:3; Grinage 2003:2405).

A study by Knoetze and De Bruin (2001) was conducted among 120 police workers to assess the role of trait anxiety in the development of PTSD. The findings indicated that

high scores on trait anxiety formed the basis of a number of criteria of psychopathology which formed an integral part of PTSD. As a result, it is likely that police candidates with high scores on trait anxiety will be more likely to develop PTSD than those with low anxiety, as individuals with low trait anxiety are generally more resistant to the negative effects of unusual situations than those with high anxiety (Van Jaarsveld et al 2007:51).

According to Van Jaarsveld et al (2007:51), police officers with high scores on anxiety and neuroticism will be more prone to suffer the negative consequences of stressful events and to develop PTSD. The author noted the importance of psychometrically assessing prospective students as part of the SAPS enlistment process. The study accentuated that those with high scores on trait anxiety for operational police work and activities should not be recommended to join the police force as they will be more prone to develop PTSD (Van Jaarsveld et al 2007:51).

PTSD is considered as one of the most common and debilitating psychological occurrences in the police service (Van Jaarsveld et al 2007:52). It is also one of the biggest causes of depression, alcoholism and suicide for law enforcement officers. Therefore, appropriate prior psychological measures should be developed basing on personality and cognitive traits of prospective candidates (Van Jaarsveld et al 2007:52).

Personalities are closely linked with the way people behave and handle stress and trauma. There are two personality factors; namely Type A and Type B groups of people. Type A (extroverts) personalities present an observable set of behaviors or style of living which is characterised by extreme competitiveness, impatience, hostility, restlessness, aggressiveness and a high state of alertness, while personality B people (introverts) are more relaxed and cooperative (Gumani 2012:82; Olivier 2009:60). Olivier (2009:60), in consideration of both personalities, noted that Type B personalities are less likely to suffer from stress, unless there is a specific cause, due to the fact that Type B people are non-aggressive, more relaxed, less driven, easy going, calm and tend to have a more rational outlook.

Olivier (2009:61) and Lynch (2007:6) noted further that Type A people are often driven by feelings of insecurity; frequently show behavior linked to high stress levels and are at risk of experiencing cardiovascular problems. A study by Kirmeyer and Diamond (1985:183), reported that police workers with strong Type A personality select more active coping strategies which are normally narrowly focused on the problem at hand. As a result, Type A personalities internalise the traumatic events they would have been

exposed to, which can be detrimental to the workers' health and likely to lead to psychological ailments such as depression, suicide and PTSD (Olivier 2009:61).

Gumani's (2012) study is of significance here. Gumani (2012:82) found that Type A police workers in the Vhembe District of the Limpopo Province used strategies that focused on confronting and dealing with situations with the goal of changing them, while Type B personality police workers reacted to stressful situations in a slow manner, deeply considering what was happening and distancing themselves from such situations.

According to Olivier (2009:57), introverted people are more vulnerable to the development of PTSD as compared to extroverts. This is because, they, in most cases, use the avoidance coping strategy, which is considered ineffective in managing trauma and PTSD, because it delays recovery.

#### ***2.5.10.6 Studies conducted on the traumatic nature of police work and its contribution to the development of PTSD***

A number of studies focusing on the nature of trauma encountered by police workers and how this leads to the development of PTSD have been carried out. Young's (2005:1) study explored alternative discourses on the experiences of trauma by the SAPS workers. The study suggested that police officers' reactions to trauma are significantly influenced by factors other than mere exposure to traumatic incidents; aspects such as history of psychological trauma indicated that constructions of traumatic stress are strongly connected with cultural, social and political circumstances (Young 2005:1).

Another study by Tehrani (2011:26), focused on 6 police officers from three policing organisations who were specifically engaged in high-risk roles including family liaison forensics, high-tech crime, computer and mobile phone crimes, and body and firearms recovery. This kind of work exposed the chosen police workers to constant trauma on a daily basis; as a result, the purpose of the study was to assess the perceptions and emotional and psychological experiences of these workers as they engaged in their high-risk policing roles. The findings indicated ineffective administrative processes, lack of support from superiors and perceived failings of the police system, which left police officers and staff exposed to traumatising events for long periods of time without a break. For example, the system allowed over identification with victims or the families

of victims which led to the development of vicarious trauma as well as increased risk of developing PTSD (Tehrani 2011:25).

Finally, a study conducted among 68 police officers in the Limpopo Province, South Africa, revealed that nearly 10% of the participants had scores which indicated that they were likely to receive a diagnosis of PTSD (Edwards 2005:132).

## **2.6 EPIDEMIOLOGY OF PTSD**

### **2.6.1 Local and international perspectives**

Epidemiological evidence in South Africa and internationally has shown that traumatising events associated with PTSD are a common occurrence (Du Plessis 2012:1). Internationally, Gilford's (2008:1) study on US military veterans found that PTSD rated among the highest disorders that the veterans presented with. Precipitating factors included repeated deployment, constant exposure to trauma and reluctance by the soldiers to seek mental care.

## **2.7 THE INCIDENCE OF PTSD WITHIN THE SAPS ORGANISATION**

### **2.7.1 Local perspectives on the incidence of PTSD among police workers**

A retrospective study by Edwards (2005:132), sought to determine the extent of PTSD in the SAPS organisation in 1987 among riot police in Cape Town and the Eastern Cape Province, and in 1988 among black police in Soweto and Pretoria. The findings indicated that 36% of the riot police and 41% of black police suffered from PTSD. Another study was conducted by Stromnes (1999:3) among police officers in KwaZulu-Natal, which aimed at determining the incidence of PTSD and whether coping and social support structures acted as mediating variables in the stress-illness relationship. The findings showed a high incidence of PTSD, approximately between 12% and 35%, among police workers, leading to a belief that PTSD may be a natural occupational hazard for people carrying out police duties (Stromnes 1999:72).

## **2.8 THE INCIDENCE OF PTSD FROM OTHER WORK CONTEXTS**

### **2.8.1 Local and international perspectives**

PTSD incidence has been documented to be high within the aircraft industry, where conflicting roles and changing circumstances call for the Air Traffic Controllers (ATC)'s skills to maintain safe operations with minimal risk of aircraft accidents (Tehrani

2011:63). The impact of operating as an ATC may include the development of PTSD. Within the health industry, Emergency Medical Workers (EMW)'s risk of developing PTSD is exacerbated by the traumatic, arduous and terrifying nature of their work (Kriek 2008:23). According to Edwards (2005:31), about 15-32% of all emergency medical personnel will be dealing with a reaction to PTSD, while 30-64% was found to have higher chances of reacting to PTSD during their lifetime.

Terblance (2006:3) observed that a relatively large number of mine workers experienced a degree of PTSD due to high incidence of injuries and death resulting from previous mining accidents (Terblanche 2006:3). Within the banking industry, Fichera Sartori and Costa (2009:2), reported that bank workers' exposure to constant acts of robbery was significantly associated with the onset of PTSD, with an increased risk for severe and long lasting impairment of emotional well-being, quality of life and work ability (Fichera et al 2009:2).

## **2.9 LEGISLATIVE FRAMEWORK**

The applicable legislative framework is circular instruction 172-PTSD. This official document defines PTSD as a mental disorder following exposure to an extreme traumatic event or stressor and further classifies PTSD as an occupational injury (Circular Instruction No. 172 2002:1).

### **2.9.1 Compensation Fund assessment for payment of PTSD disability claims**

As with other work-related injuries, the SAPS workers are eligible to claim for disability compensation for suffering from PTSD. The compensation Fund, which falls under the Compensation for Occupational Injuries and Diseases Act 130 of 1993 (COIDA) is meant to pay out certain amounts to workers who are injured at work or who fall sick as a result of work, including PTSD diagnosis [(COIDA 65(4)].

Circular instruction No. 172-PTSD (2002:1) stipulates that an employee is eligible to claim for PTSD and benefits after exposure to an extreme traumatic event or stressor arising from employment, with medically confirmed PTSD symptoms that was experienced and manifested within six months after the accident. Of crucial importance is for the employer to submit an employee's notice claim to the Compensation Commissioner within one year after the date of the accident which led to PTSD diagnosis for assessment and further processing (Circular instruction No. 172-PTSD 2002:1).

According to Adams et al (2009:1), only minority cases of workers diagnosed with PTSD are reported and a few have their disability claims fully processed for compensation. This has major negative implications for the quality of life of affected individuals as well as on their continued employment prospects (Adams et al 2009:1).

## **2.10 DIAGNOSTIC CRITERIA FOR POST TRAUMATIC STRESS DISORDER (PTSD)**

A person gets diagnosed with PTSD when he/she meets the specific criteria (DSM-IV 1994:78; Ahmed 2013:1). The diagnosis can only be made and confirmed by specialist psychiatrists (Circular instruction No. 172-PTSD 2002:1).

According to Circular Instruction No. 172-PTSD (2002:1), a PTSD diagnosis is made when the person has been exposed to and witnessed a traumatic event in which their lives or others' lives were threatened and the person reacted to the event with intense fear and helplessness. Furthermore, the person presents with persistent re-experiencing of the traumatic event through recurrent and intrusive recollections, dreams and acts as though the event was actually re-occurring. The instruction further stipulates that the traumatised person persistently displays acts of avoiding stimuli, such as thoughts, feelings, places and activities related to the specific traumatic event. The person may also show withdrawal from significant others, be easily irritable, startled and have difficulty falling asleep (Circular Instruction No. 172-PTSD 2002:1).

## **2.11 THE EFFECTS OF PTSD ON SOCIAL RELATIONSHIPS**

Overwhelming effects of PTSD have been observed on police workers' social interactions (Grinage 2003:2408; Madu et al 2006:216; Joubert et al 2013:1; Marks 1995:4). The following effects have been found by various authors to be common due to PTSD:

### **2.11.1 Interpersonal effect of PTSD on worker relations**

According to McFarlene and Bookless (2001:1), the effect of PTSD extends to interpersonal relations and can also impact on attachment behavior. Thus, the traumatic experience can become embedded in an individual's memory structure, causing a progressive avoidance of interpersonal triggers. The impact of traumatic experiences is also notable on a traumatised police workers' individual's self-awareness, intimacy, sexuality and communication, the latter being key and vital elements for maintenance of

healthy interpersonal and social relations (McFarlene et al 2001:1). Short temperedness, being emotionally detached, numbness, anxiety, violent behavior and expressing anger over trivial matters are problems normally leading to frustration and confusion among the PTSD diagnosed police worker's social network (McFarlene et al 2001:1).

## **2.12 THE EFFECTS OF PTSD ON THE FAMILY**

PTSD is known to have devastating effects on police workers' family members (Joubert et al 2013:1; Marks 1995:4; Madu et al 2006:216; Grinage 2003:2408). The following are some of the consequences of PTSD on family relations:

### **2.12.1 Marital problems due to PTSD**

According to Iniedu (2011:1) and Tull (2011:3), people with PTSD experience marital problems, which leads to stressors such as financial strain, loss of friends, having to manage the person's symptoms, dealing with constant crises and loss of intimacy (Tull 2011:3). The USA Department of Veterans Affairs (2011:61), found that PTSD sufferers were twice as likely to have been divorced (in comparison with non PTSD sufferers), and almost three times as likely to have had multiple divorces. The American Psychiatric Association (APA) (2007:5) found in a survey among deployed Iraq army veterans that those with PTSD perpetrated domestic violence at greater rates than veterans without PTSD.

A phenomenological study by Iniedu (2011:3) explored the lived experiences of a sample of 10 wives of Iraq and Afghanistan war veterans diagnosed with PTSD in order to assess the impact of the veterans' symptoms upon their wives, marriages and family lives. The study found that aspects related to fear and uncertainties about the future of their marriages, determination to keep their vows, guilt and shame, systematic change in lifestyle, mental and emotional stress were present among the veterans' wives (Iniedu 2011:3).

### **2.12.2 Behavioral effects of PTSD on relationships**

A variety of observable changes occur in a person's behavior and relations with others. These behavior changes include avoiding social interactions, preferring to be alone and detachment from others (withdrawn) (US Department of veterans' affairs 2011:58). This may limit the family members' involvement in the trauma survivor's activities



(Department of veterans' affairs 2011:58). Children and spouses of police workers are mostly affected by the changes and the affected children would normally display behavior problems (Brown 2012:2; US National Centre for PTSD 2012:1; US Department of veterans' affairs 2011:59).

### **2.12.3 Health effects of PTSD on the SAPS workers and immediate families**

Research confirmed that work-related trauma and PTSD impact negatively on public health, including the SAPS workers' and immediate family members' health and wellbeing. Scholars such as Sekwena, Mostert and Wentzel (2007:37), Roberts, Gilman, Breslau, Breslau and Koenen (2011:73), Madu et al (2006:213), Lynch (2007:1) and Piennar et al (2006:72) outlined how work-related trauma and PTSD results in increased public health consequences that include physical, social and psychological problems and illnesses such as heart disease upper respiratory tract infections, hypertension, migraines, reduced immunity, suicidal tendencies, cardiovascular irregularities and, peptic ulcers, as well as behavioral problems such as emotional disturbances, alcohol and drug dependence abuse, domestic violence, s and anxiety. In addition, people with PTSD have been found to be six times more likely to develop depression as compared to people without PTSD (Tull 2011:1).

### **2.12.4 Poor management of effects of traumatic incidents**

Families may become isolated due to the social anxiety the PTSD sufferer experiences (Ray & Vanstone 2011:3). For example, a police worker's health condition can directly or indirectly put pressure on family members and force them to stay home due to changes in emotions by the worker. This may have a detrimental effect on how the family socialises with friends and extended family members, leading to guilt feelings in cases where family members pursue independent activities, such as attending social activities out of family settings, while leaving the suffering police worker at home (Ray et al 2011:3).

Difficulties in managing feelings of anger lead to a chaotic atmosphere of separation, lack of trust and cohesion due to family members pulling away to avoid hostility (Sherman, Sherman & Edina 2005:15; Ray et al 2011:3). Furthermore, family members of the SAPS workers diagnosed with PTSD may be at a greater risk of exposure to higher levels of verbal abuse, such as yelling and name calling, as well as physical

abuse such as throwing and kicking things at home, due to changes in moods and emotions as a reaction to trauma (Ray et al 2011:3).

#### **2.12.5 Feelings of rejection and guilt experienced by family members due to PTSD**

Family members may experience feelings of rejection and loneliness due to an unwillingness to share feelings with loved ones. Sometimes family members blame themselves for their loved one's emotional distance. Thus, family members usually struggle with emotional expression and self-disclosure (Ray et al 2011:3), encounter difficult experiences and fail to express positive feelings due to emotional numbing which is common with PTSD (Cook, Schnurr & Foa 2004:25). The negative effects of this traumatic reaction are especially noted among children. Children suffer by virtue of the police worker's inability to acknowledge neither the children's strength nor reward their efforts within the family setting (Ray et al 2011:3). The latter contributes negatively to their development and can lead to an inability to meet the children's emotional needs and to an observable detachment within families (Ray et al 2011:3; US Department of veterans' affairs 2011:59).

#### **2.12.6 Effects of mental stress on family members**

According to Riggs, Byrne, Weathers and Litz (1998:1), a preoccupation with managing mental stress may result in PTSD sufferers being emotionally distant from their family relations and less intimate with spouses and partners. Sleep disturbances due to constant nightmares, and insomnia, specifically during nightmare episodes, can be frightening, especially for spouses, children, parents and siblings. Sleep disturbances, resulting from the trauma of fighting with criminals at work or a combat situation, are characterised by physical aggression in the midst of a nightmare and the perception that the spouse as an enemy. New sleeping arrangements may be established here and this may lead to limited physical intimacy (Ray et al 2011:15; US Department of veterans' affairs 2011:61). Finally, this may lead to separation between the couple.

Families are still governed by the traditional male or female roles; notions on primary family breadwinner, head of the household, manager of family finances and carer for the family, and the need to ensure children's wellbeing, even in cases where someone is suffering from PTSD emotional instability (Ray et al 2011:17). These traditionally gender assigned roles may be overwhelming for families and this lead to an inability to

pursue personal goals due to having to take over many of the PTSD sufferer's responsibilities. Children may have to acquire adult responsibilities at an earlier age, resulting in quick maturity and sometimes taking on the role of a "parentified child". Thus, children might be compelled to pursue adult family roles at a young age due to a parent's difficulty to manage usual family roles and responsibilities (Ray et al 2011:17).

A study by Sekwena et al (2007:38) determined the interaction between work and personal life within the experiences of police officers in the North West Province. The sample population comprised of 10 male and female police workers from Potchefstroom and Klerksdorp police stations. The findings indicated that the stressful and traumatic nature of policing work had a tremendous effect on the worker's personal lives, household duties and family responsibilities (Sekwena et al 2007:38).

## **2.13 THE EFFECTS OF PTSD ON THE SAPS ORGANISATION**

### **2.13.1 Increased disability claims due to PTSD**

According to Van Wyk and Edwards (2005:137) and Olivier (2009:43), PTSD has emerged as a significant problem among the SAPS workforce. Since the first democratic Government election in 1994, there has been a dramatic increase in disability claims on the basis of chronic PTSD within the SAPS organisation (Van Wyk et al (2005:137). Provincial Statistical data on the number of the SAPS workers diagnosed with PTSD as a result of execution of official duties for the period of 2005 to 2012 indicated that 61 workers were diagnosed with PTSD in the North-West province (The SAPS Occupational Injuries report 2012:1).

Statistical data on medical and disability costs for compensating the SAPS workers diagnosed with PTSD shows that 94 workers received awards of compensation during the period 2005 and 2012 in the North-West Province alone (The SAPS Occupational Injuries report 2012:1).

### **2.13.2 Increased cases of police ill health and medical boarding**

A study by Mofamere (2003:18) conducted in the SAPS organisation, which sought to enquire how a police chaplain could be enabled to manage cultural diversity within the SAPS Gauteng Province workforce. Mofamere (2003:18) concurred with findings by Mokoka, Rataemane and Dos Santos (2012:34), Young (2005:27), Joubert et al (2013:1), Van Wyk et al (2005:136), Edwards (2005:125), Tehrani (2011:117), Leino et

al (2011:400), MacDonald et al (2003:6), Van Lelyveld (2008:16), Stegiopoulos, Bonato, Cimo, Cheng and Dewa (2011:9) and Tull (2011:2), which underscored that stress and anxiety related conditions such as PTSD are prevalent within the SAPS workforce, leading to increased absence from work and medical boarding cases, suicides and police deaths. Furthermore, with regards to police workers experiencing ill health, Young (2005:27) and Van Wyk et al (2005:136) noted that most of the 110 police officers from the Eastern Cape who had been certified ill by medical doctors, suffered from PTSD. Young (2005:27) and Van Wyk et al (2005:136) regarded PTSD as a route to medical boarding within the SAPS organisation.

The North-West Province's SAPS workers who were found to be medically unfit due to PTSD for the period of 2005 to 2012 amounted to 94 workers. These workers retired on PTSD medical grounds (The SAPS Occupational Injuries report 2012:1).

## **2.14 COPING MECHANISMS USED BY POLICE SERVICE WORKERS TO DEAL WITH PTSD**

### **2.14.1 Response strategies to coping with PTSD**

Police workers with different personality characteristics employ various strategies to cope with traumatic experiences (Gumani 2012:82; Taylor 2008:1; Emmelkamp et al 2002:1465; Young 2005:75). These include : (1) problem-focused methods which cater for interpersonal efforts and actions that aim to modify or eliminate the source of the trauma and channel resources to solve the trauma-inducing problems; (2) emotion-focused coping which involves an attempt to manage emotional distress associated with stressful situations through relaxation, the use of substances (alcohol or drugs), engaging in anti-social activities and using defense mechanisms as well as avoidance (Myendeki 2008:9; Taylor 2008:1; Emmelkamp et al 2002:1465).

The problem-solving approach is normally used in situations where chances are that the problem can be solved by applying constructive actions to the stressor. However, emotion focused coping is more likely to be applied in situations where there is a belief that the situation is uncontrollable and has little chances of altering the situation (Myendeki 2008:9; Taylor 2008:1; Emmelkamp et al 2002:1465).

#### **2.14.2 Emotion and problem-solving coping strategies**

Young (2005:75), Mabe (2004:34), Taylor (2008:1) and Myendeki (2008:12) asserted that emotion-focused coping; specifically defense mechanisms such as denial and avoidance which are about the refusal to believe that the stressor is real and one of refusing to face the trauma-inducing event, were as pathological and maladaptive, and therefore not considered to be an effective coping strategy. On the other hand, problem-focused strategies were found to be adaptive to the difficult conditions (Mabe 2004:34; Wiese et al 2003:72). Implementation of both problem-solving and emotion-focused strategies is encouraged among police workers, given the demanding nature of their work (Wiese et al 2003:72). This will assist with maintaining emotional balance, self-control and problem solving and to achieve a positive mental health (Lynch 2007:6; Young 2005:72).

A study by Stromnes (1999:3) conducted among police officers in KwaZulu-Natal sought to determine the incidences of PTSD and examine whether coping and social support structures acted as mediating variables in the stress-illness relationship. The results showed that emotion-coping strategies such as self-blame and wishful thinking were found to be predictive of PTSD.

#### **2.14.3 Practicing body and mental relaxation techniques**

Other effective coping strategies include practicing relaxation exercises (Tull 2010:5). These have been found to be a powerful tool in managing the fear and anxiety accompanying PTSD diagnosis.

#### **2.14.4 Connecting to spirituality**

Relying on divine intervention to successfully manage the effects of trauma was used by most police workers in a study by Gumani (2012:328) which analysed the personal coping strategies used by police workers in the Vhembe District of the Limpopo Province. Spiritual connections were also found to be helpful by Young's study (2005:164) which explored the meaning of trauma among the SAPS workers. The findings observed that the participants' ability to connect with any form of spirituality acted as a meaningful coping mechanism for trauma.

#### **2.14.5 Use of management and peer support**

Support received by workers who are traumatised and those diagnosed with PTSD from commanders and fellow colleagues is crucial (Gumani 2012:390; Pillay 2008:22). A study by Wisniewski and Gargiulo (1997:1) noted that PTSD can be managed through social support systems, within the family network, social life and in the workplace. Support by administrative management, superiors and colleagues have been identified as a powerful tool for ameliorating PTSD symptoms, especially in the workplace (Pillay 2008:22; Van Lelyveld 2008:12; Wisniewski et al 1997:1).

According to Young et al (2012:10), feeling supported and recognised alleviates feelings of vulnerability and acts as a trauma membrane. Study findings by Mabe (2004:63) showed that about 79.41% of the police workers highlighted the need for the SAPS managers to support and empathise with workers in an endeavor to assist with morale enhancement as well as coping with trauma and PTSD (Mabe 2004:63).

#### **2.14.6 Enhanced coping skills**

Kajee and Jones (2005:209) investigated the relationship between coping style, perceived social support, and length of service experience, age and gender on symptoms of post-traumatic stress, among 116 SAPS workers in the Western Cape Province. The results indicated that there is a need to enhance coping skills among police workers in addressing duty-related traumatic stressors and to fortify social support structures both within the police service and in the private lives of the workers (Kajee et al 2005:209).

#### **2.14.7 Family sense of duty**

The need to earn a living to cater for the individual police worker's basic family needs, especially ensuring that their children get proper education, thus building a better future for their families as well as feeling obliged to do policing for the survival of their families, served as a coping mechanism for most police workers in Gumani's (2012:328) study. This sense of family responsibility assisted police workers to hold on to their jobs, regardless of the work-related and traumatic experiences they were exposed to on a daily basis (Gumani 2012:328).

#### **2.14.8 Professional counseling**

A qualitative study by Tehrani (2011:17) looked at the perceptions and emotional and psychological experiences of 6 police officers from three policing organisations, who had worked for a minimum of 3 years in high-risk roles, which included family liaison, forensics, body recovery and fire-arms. The findings indicated the need for regular professional consultation by police workers, especially the ones performing high-risk roles, to provide them with an opportunity to “talk” about their work with an independent person. These independent people should be trained to identify symptoms of stress and trauma and can act as trauma counselors, psychologists or social workers.

Participants in Tehrani’s (2011:17) study got confidential personal support from an occupational health nurse or counselor, to deal with family issues impacting on work performance and on families. Thus, when a partner is directly affected by the impact of policing work, consideration should be given to also providing support and counseling to the affected families.

The findings from the study by Tehrani (2011) concurred with those from Gumani (2012:352) in noting that SAPS organisation’s debriefing and management support sessions involved the use of internal and external counseling services, which included consulting with a social worker, psychologist or psychometrist and a chaplain. Police workers could also consult with mental health professionals outside of the SAPS environment, including medical doctors, magistrates and social workers. The consultations are either self-initiated or a referral by a supervisor upon noticing signs of distress among police workers (Gumani 2012:352). This confirmed Yehuda’s (2002:112) view that counseling is an important component in the treatment of traumatised people.

#### **2.14.9 Use of substances to manage trauma**

Some police workers use alcohol, which acts as an anesthetic, to repress trauma related reactions such as painful memories, anxiety, and cynicism (Young et al 2012:5, Madu et al 2006:216; Lynch 2007:1; Young 2005:76). There abuse of alcohol and drugs was found to be widespread within the SAPS organisation (Mabe 2004:63; Young 2005:76). Jorgensen (1999:1) concurred with the findings by Mabe (2004) and Young (2005) that a visit to the canteen after strenuous, traumatic exposure is normally a common occurrence, which trauma literature found to be associated with a sign of

masculinity by the SAPS workers. This visit is often characterised by the consumption of huge amounts of alcohol.

#### **2.14.10 Individual resilience and cultural practices**

Kgalema's (2002) study found out that Metropolitan police workers in South Africa relied on individual emotional strength and resilience instilled by cultural practices to manage the effect of trauma. For example, growing up in disadvantaged family settings somewhat trained these police workers to have a sense of internal strength in the face of difficult life demands (Kgalema 2002:17). According to Gumani (2012:160), culture has an immense influence with regard to coping with trauma, thus individuals from different backgrounds respond differently to trauma due to what their cultures emphasise. The way individuals define and understand stressors differ, as well as the way they perceive, prefer and implement various coping mechanisms to manage trauma (Gumani 2012:160).

#### **2.14.11 Support from family and friends**

Trust embedded in family members and friends allowed ventilation of emotional strain caused by traumatic incidents and PTSD experienced by police workers (Kgalema 2002:18; Pillay 2008:21; Tull 2010:5; Gumani 2012:382). These members included the immediate and extended family such as spouses, children, parents, parents in-law and siblings who instill courage and perseverance, and inner strength in officers as they face challenges in their work (Gumani 2012:382).

Findings by Sekwena et al (2007:53) regarded active communication, receiving support from spouse or partner, participating in various activities, spending less time with work colleagues outside the work environment and actively separating work life from home life as effective coping mechanisms. These mechanisms assist in dealing with the stressful interaction they experienced between their work and personal lives.

#### **2.14.12 Self-monitoring and practicing sports and hobbies**

Monitoring one's trauma symptoms is important in everyone's life. An awareness of the situations triggering PTSD symptoms and taking part in positive life activities, especially the ones the trauma survivor used to enjoy prior to trauma exposure, is important in dealing with avoidance symptoms experienced after trauma. For example, engaging in mental and physical sports activities and hobbies, can have a positive influence on



one's ability to overcome traumatic experiences (Tull 2010:5). Study findings by Mabe (2004:64) indicated that 83.23% of the participants fully agreed that police officials can effectively cope with life demands, including PTSD if they are encouraged to actively partake in sports and hobbies.

## **2.15 POLICE CULTURE AND ITS IMPACT ON COPING WITH TRAUMA AND PTSD**

According to Omar (2008:2), most male police workers believe that maintaining a “macho” image is a pre-requisite of their job. They believe that they may be seen and viewed by peers, colleagues and community members as weak and unable to do their job if they seek professional help to manage PTSD (Dussich 2003:9; Marks 1995:7). The findings concurred with Mabe's (2004:67) observation. According to Seanego (2012:1), most police workers have myopic perceptions regarding counseling, hence inadequate utilisation of the SAPS health management and its Psychiatric Disease Risk Management Programme. The findings highlight further that most police workers' major problem lies with their view that they will be considered as weak if they report for counseling (Seanego 2012:1). According to Tehrani (2011:31), being macho and avoiding talking about trauma can result in emotional dissociation and a lost opportunity to learn and develop greater skills and resilience.

The organisational culture of the SAPS, including the nature of police training, to a certain degree do not allow for the processing and displaying of traumatic emotions or talking about one's daily experiences (Mabe 2004:16; Van Wyk et al 2005:138). Further findings by Mabe (2004:62) stated that 73.53% of the participants said that the problem with the police is that they “do not want to open up” about their problems.

### **2.15.1 Closed police sub-culture**

Young (2003:38) and Pillay (2008:22), referred to law enforcement as a “closed police sub- culture”. Thus, most police officers are distrusting in nature, and do not easily ask for help from friends, family members or mental health professionals in order to deal with their traumatic experiences. Most police officers may however feel comfortable talking about work related trauma among colleagues and those with the same type of background as them. The main issue at play here is the belief that commanders and colleagues have a better understanding of the experiences of being a police officer than non-police workers (Pillay 2008:22).

Belonging to a police sub-culture means being aware of explicit rules and implicit codes which only police workers understand (Pillay 2008:22; Gumani 2012:33). The author further echoed that belonging to this sub-culture promotes learning to work with and depend on each other for safety. This sense of police togetherness, group cohesion and dependence on one another contributes to some police workers isolation and not opening up to 'outsiders' such as family members, professionals and friends. The same police officers are however able to establish internal support from the 'insiders', such as fellow police officers, whom they trust and know will not judge them (Van Lelyveld 2008:11; Marks 1995:7). This cohesiveness can serve as a buffer against experienced work-related trauma (Pillay 2008:22).

Tehrani (2011:19), in line with observations by Pillay (2008), underscored that many police officers prefer not to talk about the more distressing aspects of their work with their spouses and professionals. In most cases, the police officers do not to share their work-related challenges and traumatic experiences. As a result, the impact of unresolved trauma spills into personal relationships.

## **2.16 POLICE PERCEPTIONS ON TRAUMA DEBRIEFING SERVICE AS A COPING STRATEGY**

A study by Van Wyk et al (2005:138) found out that most police officers to whom debriefing was offered experienced and regarded it as a waste of time. However, the latter findings differed from studies conducted by Maabela (2011:56) and Chabalala (2005:80) which found that most police officers, in the Mahikeng area of the North West Province and Gauteng Province perceived and experienced trauma debriefing services as good, helpful and effective counseling sessions, as well as encouraging solidarity within the SAPS organisation.

Findings by Kopel et al (1997:307) indicated that police officials deal with exposure to trauma by distancing themselves from unpleasant experiences and avoiding dwelling on it, thus applying the avoidance coping strategy. The author hypothesised that denialism and avoidance are part of a macho police culture (Kopel et al 1997:307; Van Wyk et al 2005:138). According to Ahmed (2007:371), avoidance style predicts an increase in PTSD symptoms. On contrary, Maabela's (2011:50) findings were that police officers who took part in the study (84%), preferred "talking about the incident" as a way of coping and dealing with the effects of trauma.

Mokgobu (2010:2) observed that there was unwillingness by most traumatised police workers to make use of the SAPS organisations' crisis line, which offered 24 hour counseling. The unwillingness was closely linked to the stigma attached to social workers, psychologists and counselors and the shame of seeking professional help (Mokgobu 2010:2; Mabe 2004:65; Pillay 2008:22; Seanego 2012:1). Rajin (2012:5) asserts that constant exposure to traumatic incidents without counseling may lead to PTSD.

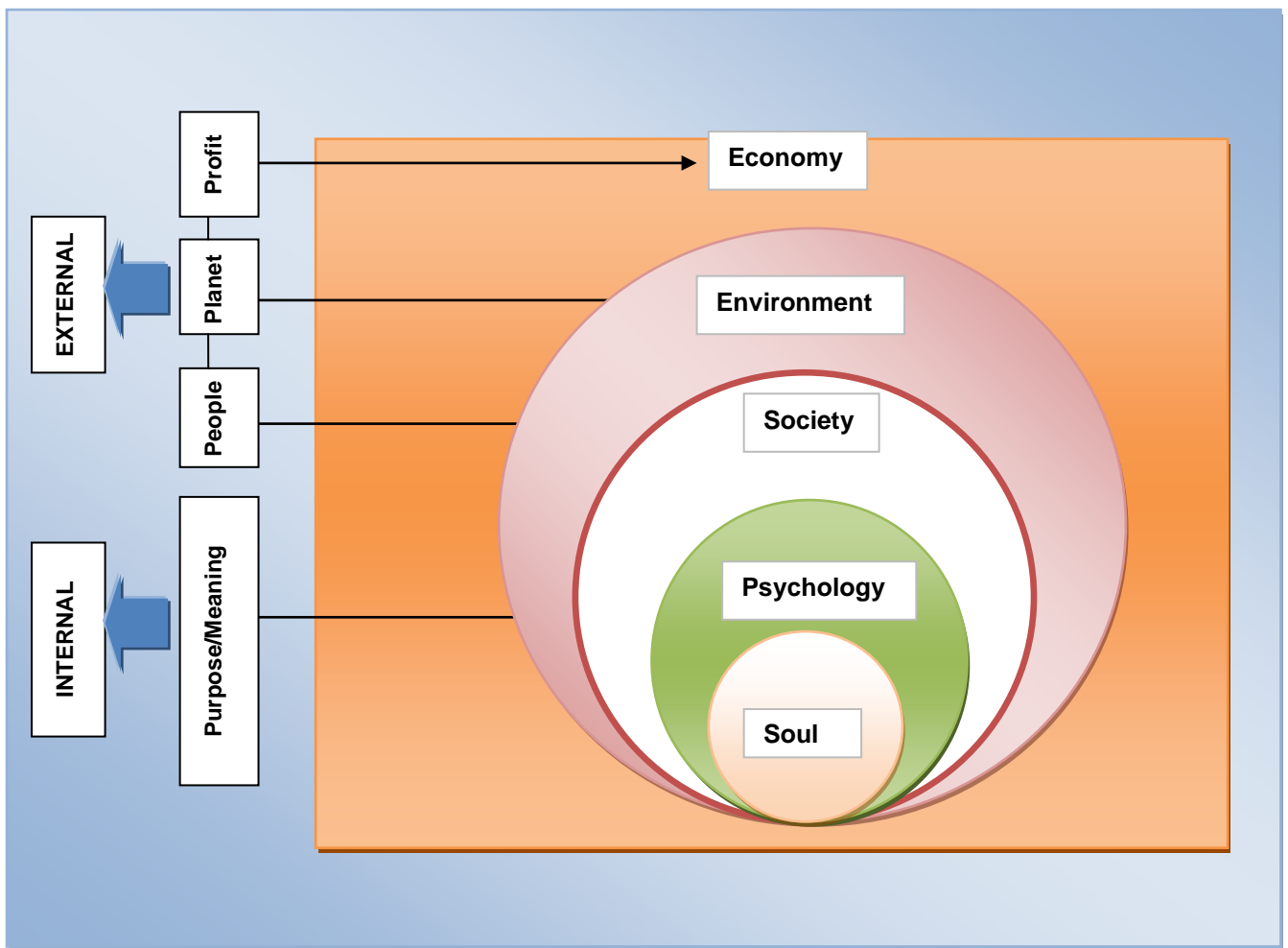
## **2.17 OCCUPATIONAL HEALTH INTERVENTIONS AND SUPPORT PROGRAMMES FOR MANAGEMENT OF PTSD**

Topp (2010:1) emphasised the importance of employers ensuring workers' internal sustainability, which refers to caring for their soul and emotional well-being. This ultimately creates meaning for the workers and leads to psychological sustainability within the workplace. The author argued further that meaningful workplaces play an important role in workers' lives, and reflects their deeper values and aspirations (Topp 2012:1).

Prioritising workers' physical, mental and emotional wellbeing leads to increased intelligence, engagement and energy which enhances peak performance, consequently contributing positively to the country's society and economic development (Topp 2010:1). On contrary, a weakening psychological and physical care for the workers, leads to less meaningful work, depression, emptiness and may result in physical illnesses (Topp 2010:1).

Given the traumatising nature of police work, (Garbarino et al 2011:395; Steyn et al 2013:20), there is a need for the SAPS organisation to ensure an adequate workers' psychological (care of the soul) wellbeing (internal sustainability) while contributing to the safety and security of the external environment/ community and society (external sustainability).

Below is a graphical illustration of the link between internal and external sustainability.



**Figure 2.1: An illustration of facets of sustainability - emanating from the soul (centre)**

(Source: Topp 2010)

### **2.17.1 Management of PTSD among police service workers in South Africa: Primary, Secondary and Tertiary levels of prevention**

Various health and wellness programmes and strategies are implemented within the SAPS organisation to render support to workers and families, and manage vicarious trauma and PTSD (Rajin 2012:1). They are classified below as Primary, Secondary and Tertiary levels of Prevention.

### **2.17.1.1 Primary prevention strategies**

Primary prevention programmes that are pro-active in nature, which seek to minimise the negative effects of trauma by intervening before an incident takes place (Tehrani 2011:205). These are programmes which provide individual police workers with information and skills to enhance their readiness, thus to “psychologically prepare them” (Tehrani 2011:205).

#### **2.17.1.1 Pre-deployment briefing**

This prevention strategy includes pre-trauma exposure empowerment. It equips workers with ways of coping with exposure to trauma by offering classroom-style operational pre-deployment briefing sessions that set expectations of crime combating skills for police workers (Tehrani 2011:205).

#### **2.17.1.2 Pre-selection screening**

There is need to administer and interpret psychometric tests to assess and determine police applicants’ personality, functional literacy and general coping abilities prior to enlistment. Thus, assessing whether applicants fit the profile of a typical police worker, who will be able to manage the demanding nature of police work as prescribed by the police organisation, is crucial as it will enable the organisation to appoint suitable police candidates (Tehrani 2011:222).

According to Van Jaarsveld and Schepers (2007:51), the ability of police workers to fulfill the responsibilities of upholding the standards of society and enforce rules regulating life in the country may depend on their personal values, characteristics, behavior (personality) and activities, i. e. understanding law enforcement personnel attributes. Van Jaarsveld and Schepers (2007:51) highlighted that “stable” personality characteristics are the strongest determinants of a police officers’ wellbeing. In addition, Gumani (2012:138) argued that selected police workers need to be of a good mental health to allow for an effective coping with traumatic events.

#### **2.17.1.3 Creating meaning in policing work**

This includes encouraging police workers to establish the meaningfulness of their work and their reason for doing it (Tehrani 2011:26). This involves having time to prepare and thinking through what one may need to do to meet a traumatically challenging event. In

a study by Tehrani (2011:27), police workers indicated that finishing the job and safely returning back to families, brought about a peace of mind (Tehrani 2011:27).

#### **2.17.1.4 Induction training**

Induction of training helps new police recruits to settle well and move quickly in their new roles (Tehrani 2011:222). Conducting police induction training with the aim of equipping workers with the very traumatising nature of police environment, and effective trauma management techniques are crucial as they psychologically prepare the police workers (Gumani 2012:133; Tehrani 2011:223).

#### **2.17.1.5 Relief humor**

Police workers use relief humor to release pent-up energy caused by emotional, physiologically demanding and traumatising incidents (Tehrani 2011:28). According to Tehrani (2011:28), humor can be used to help detach from immediate surroundings and also enables situations to be re-framed by letting people to psychologically step back and adopt a different perspective on their work (Tehrani 2011:28).

Pillay (2008:20) and Tehrani (2011:28) posited that humor provides some form of tension and aggression release. Both argued further that it can also provide a re-interpretation of a traumatic event, can be a way of lessening the emotional impact of trauma, and can serve as an effective emotional communication tool among emergency personnel. The use of a specific type of humor called black or relief humor, where police workers joke about the traumatic incidents they would have been exposed to, should, however, not be done excessively, as its overuse can be an indication of distress (Pillay 2008:20).

#### **2.17.1.6 Life skills programmes presentations by internal and external professionals**

There is need for a consistent presentation of life skills programmes at police training colleges prior to practical exposure to work-related trauma. This exposure equips the workers, at an early stage, to effectively manage personal and job-related stress and inform them of available support programmes and services rendered by the EHWP, including contact details of available external professional resources (Gumani 2012:133).

### **2.17.1.7 The SAPS worker health and wellness days and sporting activities**

According to Rogers (2011:1), Hart (2012:4) and Bennet (2010:3), regularly arranging worker wellness days packed with various sports and recreational activities with maximum employee participation across all ranks encourages and promotes team building and the maintenance of a team spirit at workplaces. These also enhance interpersonal relations through close interaction in various physical and mental activities.

The wellness events also include health related activities such as health screening to checkup for blood pressure (hypertension), blood glucose, Body Mass Index (BMI) and Tuberculosis (TB). Other events include the eye and ear checkup and cholesterol level check, which together with the aforementioned aim at pro-active health management, avoiding disease development and detecting diseases at an early stage for effective treatment and control. Employee wellness days promote preventive care, generate sustainability for a healthy lifestyle and initiate healthy activities on an on-going basis, thus, fostering healthier workplaces (Bennet 2010:3; Hart 2012:4).

Active participation in various sporting activities assists with effective stress and trauma management (Tulloh 2012:1). Police workers can partake in the workplace sports programme such as the management approved sports Wednesdays within the organisation. Use of community sports, health and fitness clubs allows physical and mental activity which is closely correlated to mental and physical wellness and effective coping with trauma and PTSD (Tulloh 2012:1).

### **2.17.1.2 Secondary interventions**

Secondary prevention strategies include actions taken in the acute aftermath of trauma, with the aim of easing the effects thereof and preventing the development of chronic illnesses (Tehrani 2011:207). These strategies are targeted at a specific at-risk population in an attempt to reduce their likelihood of developing specific mental and behavioral health problems (Ford 2009:252; Balenger 2010:2). The strategies include the following:

#### **2.17.1.2.1 Psychological First Aid (PFA)**

This form of secondary approach to PTSD prevention is usually offered to victims of disasters such as hurricanes, floods, industrial explosions or mass terrorist traumatic

incidents (Ford 2009:258). This method has been found to be efficient in providing psychological and practical information, as well as on-the spot support and resources to people affected by mass casualty trauma incidents (Ford 2009:252). Psychological assistance under PFA includes assisting victims to feel safe and stabilising their emotional reactions to cope with the trauma, as well as providing information on where to access available mental health counseling (Ford 2009:253).

#### *2.17.1.2.2 Trauma debriefing Critical Incident Stress Debriefing (CISD)*

Psychological support in the form of trauma debriefing sessions has been identified as helpful (Gumani 2012:134; Young 2003:5). According to Ford (2009:274), CISD has become a most widely used secondary prevention method, locally and internationally. The implementation of an ongoing debriefing programme benefits individual police workers in that it results in reduced job stress, increased job satisfaction, less anxiety, and perception of the SAPS department as more personally supportive and less likely to develop PTSD. Friends and family members benefit as the traumatised workers experience fewer and less severe symptoms and effects of trauma and PTSD (Young 2003:5).

Traumatised workers within the SAPS organisation are offered trauma debriefing sessions in order to manage the effects thereof. This is according to the SAPS National Instruction No 18 of 1998. According to this official document, all SAPS workers who have been exposed to trauma must report for debriefing. This instruction is issued in an attempt to provide for the effective debriefing of traumatised employees. The document further asserts that if traumatised employees do not receive timeous debriefing, which should be conducted within 72 hours of the incident, a real danger exists that they will develop Post Traumatic Stress Symptoms (PTSS). Failure to conduct the debriefing in the officially stipulated 72 hours places the employees at high risk of development of PTSD (Young 2005:29; Maabela 2011:27).

Gumani (2012:139), Pillay (2008:27), Omar (2008:2) and Van Wyk (2011:2), viewed the issue of trauma debriefing as a serious challenge within the SAPS organisation. They observed that the fear of displaying emotions, the risk of being identified as seeking help and stigmatisation attached to it prevents most police workers from taking advantage of the available counseling services. Gumani (2012:136) and Van Wyk (2011:2) also identified lack of trauma debriefers as a shortcoming for this programme.



Omar (2008:3) echoed the importance of the SAPS management ensuring maximum utilisation of debriefing services for the benefit of the SAPS organisation and ultimately for the welfare of the South African public. The results from a study by Gumani (2012:371) indicated that there is a lack of awareness of the debriefing services by police workers. Further findings indicate avoidance of debriefing services by both male and female police workers as rife, and underscored that ignorance and a disregard of these services was highly reported among male police workers (Gumani 2012:372).

Other reasons for under-utilisation included a general undermining of the value of trauma debriefing services. Some police workers did not see the importance thereof and perceived counseling as a mere talk and agreement by EHW counselors and trauma debriefers. Police workers actually perceived themselves as well adjusted within the work environment, for participants acknowledged the effects of traumatic stress on their work, personal and social lives, but viewed it as trivial and not severe enough to disrupt their functioning at various areas and levels of their lives and thus did not call for professional intervention (Gumani 2012:372).

According to the Minister of Police report (2010:1), some of the SAPS workers also utilised external psychologists for trauma counseling by means of their medical benefits. A report by De Beer (2012:2) and the Minister of Police report (2010:1) with title *“Police Minister Nathi Mthethwa urges police officers to utilise the South African Police Services (SAPS) wellness”* indicated that the SAPS management does encourage usage of professional services among its workers. According to Omar (2008:2), more needs to be done to make officers aware of available workplace support programmes among the SAPS workforce.

#### *2.17.1.2.3 The SAPS trauma debriefing model*

The trauma debriefing model used within the SAPS organisation was developed by Jacobs and Watson (1992), which was adapted from the well-known Critical Incident Stress Debriefing (CISD) model by Jeffrey Mitchell (1983). The SAPS model is characterised by educational, supportive and open experience with absolute confidentiality as the main goal of managing trauma (Maabela 2011:28).

A qualitative study by Pillay (2008:2) explored perceptions of the SAPS trauma debriefers basing on six psychologists who use Mitchell's (1983)'s CISD model as an intervention tool with traumatised police workers based in Durban and Pietermaritzburg

(KwaZulu-Natal Province). Findings from this study indicated that the CISD model has value when used as a group intervention. However, due to continuous exposure to trauma, the model needs to be adapted or changed to suit the dynamic police work environment. Further results showed that due to continuous use of this model, most of police workers became too familiar with it and as such the model began to have less impact on trauma management (Pillay 2008:91)

#### *2.17.1.2.4 Specific benefits of trauma debriefing*

Individual traumatised SAPS workers who effectively use trauma debriefing services may enjoy a number of benefits. These benefits include: a) ventilation of traumatic experiences in a safe, non-judgmental and supportive environment, b) minimised risk of developing PTSD, c) reduction of interpersonal problems, d) reduction of short and long term after effects of trauma. e) reduced levels of anxiety if one has to ask for help, f) the realisation that the reactions toward the traumatic event are normal and g) the realisation that the organisation does care about them as individual workers contributing towards the achievement of the organisation's goals (Maabela 2011:29).

As part of the duties of a former SAPS EHW practitioner, the researcher offered trauma debriefing services to the SAPS workers and their immediate family members. The researcher was concerned about the limited number of SAPS workers who reported for trauma debriefing services. As a result, a study was conducted with the aim of determining perceptions and experiences of SAPS workers in the Mahikeng area regarding trauma debriefing services and to describe their experiences on exposure to trauma.

The findings showed that the Mahikeng SAPS workers perceived trauma debriefing services as helpful counseling sessions, support from colleagues and a source of team solidarity. These results concurred with findings from a qualitative study by Chabalala (2005:76), who also explored experiences and perceptions of the SAPS workers stationed at the SAPS Head office in Pretoria. The findings by Chabalala (2005:82) indicated that trauma debriefing was experienced and viewed by participants as a good and effective strategy in managing trauma, thus further highlighting that the SAPS debriefing programme must be pro-active rather than re-active (Chabalala 2005:82).

Ncokazi's (2002:1) study investigated the reasons behind non-reporting for debriefing by SAPS members. The findings showed that 74% of the study sample was familiar

with the nature of the process and purpose of the debriefing services. However, 80% of the participants had not attended trauma debriefing sessions before. Non-reporting for trauma debriefing by SAPS workers was a major concern for the former Minister of Police. In a speech during the opening of the new POLMED House in Pretoria, during the month of June 2012, the Minister appealed to the POLMED board of trustees to assist officers suffering from stress and emotional trauma (Seanego 2012:1).

#### *2.17.1.2.5 A 24-hour crisis intervention and stand-by service*

Provision of one to one or family group sessions to the SAPS workers and families in the form of a 24 hour emergency standby services renders an immediate EHW services for incidents such as family domestic violence, suicide threats and attempts, anger, aggression or overwhelming grief after loss (Ford 2009:275). Crisis intervention assists workers to manage problems requiring immediate attention.

#### *2.17.1.2.6 Health education*

Education, through workshops and training sessions increases police awareness on various health and wellness matters such as the effects of stress and its management, burnout, vicarious trauma and coping strategies (Tehrani 2011:224; Wiese et al 2003:78). Higher education correlates with the ability to regulate emotions and seek social and professional assistance and it also empowers workers on the importance of not alienating from others after trauma (Gumani 2012:133). According to Yehuda (2002:112), education helps trauma patients understand the nature of their condition and the recovery process.

#### *2.17.1.2.7 Resilience building*

With this strategy, the SAPS workers, specifically those undertaking similar tasks, such as crime prevention and investigation, and photo and finger print police workers are enabled to discuss common issues or difficulties arising within their work and encouraged to engage in consultation in order to resolve their difficulties (Tehrani 2011:225). Resilience building includes working teams that meet on a regular basis, usually every 4-6 weeks. The meetings should be coordinated by a facilitator who is trained in the resilience-building model of trauma support and based on the principles of narrative therapy. This strategy is helpful as it encourages work-related concerns to be challenged, externalised, reviewed and reframed, leading to team members learning

from each other and reduce barriers negatively affecting work performance (Tehrani 2011:225).

#### *2.17.1.2.8 Commander training on basic and advanced management and on the SAPS EHW Programme*

It is essential to train commanders on various leadership and management styles and roles, employee health and wellness programme (EHW supervisory training) and on the importance of ensuring a supportive work environment. The commanders ability to understand their supportive role and to identify and refer workers requiring professional assistance will enhance workers performance and a sense of care provided by the employer (Yehuda 2002:113; Topp 2010:1; Gumani 2012:133; Tehrani 2011:224).

#### **2.17.1.3 Tertiary interventions**

Tertiary interventions are designed for workers who have already developed PTSD, with the goal of preventing PTSD from becoming long lasting or severe (Ford 2009:252). Tertiary interventions within the context of the SAPS organisation will include the following:

##### *2.17.1.3.1 Internal and external referral of the SAPS workers for psychiatric and medical treatment*

Trauma counseling and therapy to the SAPS workers should be provided (Wiese et al 2003:78). They should also have access to professional consultants, such as experienced medical doctors and specialist psychiatrists, outside of the organisation for specialised intervention and support; counseling and medication; and receipt of anti-anxiety or antihypertensive (blood pressure) medication, in order to reduce physiological reactivity to traumatic memories and thus assist with trauma and PTSD management (Ford 2009:277). Further therapy can be in the form of referrals of SAPS workers from external professionals for intra-organisational assistance and support as well as referral of the SAPS workers to other mental health professionals within (to other SAPS EHW professionals) the Saps organisation for specialised assistance when necessary (Bell 2003:466).

There is also need to be pro-active in developing or linking clients with other support services. These include self-help groups in and out-patient hospitalisation and

accommodation of victims of violence, rape, and trauma during time of distress, and provision of resources for payment of these services that support both the community members and police workers, which ultimately promote a sense of “attitude of respect” and team work leading to enhanced work morale (Bell 2003:466).

#### *2.17.1.3.2 Trauma counseling, clinical counseling and therapy*

Tertiary strategies may include referrals of workers to psychologists for counseling and therapy (Tehrani 2011:93; Yehuda 2002:112). The use of varying evidence based, integrated cognitive-behavioral, emotional and spiritual approaches (Balenger 2010:1) as therapeutic intervention methods has been found to be successful in the prevention of PTSD. The specific methods often used include Cognitive Behavioral Therapy (CBT) exposure therapy, pharmacotherapy and Eye Movement Desensitisation and Reprocessing (EMDR) (Tehrani 2004:93; Levy 2012:3; Yehuda 2002:113; Hamblen 2010:1; Ford 2009:276).

#### *2.17.1.3.3 Trauma support groups*

Social interaction, after a traumatic event, with supportive groups assists in the reduction of psychological symptomatology (Martz & Lindy 2010:27; Young 2005:73; Amaya-Jackson & March 1995:1). Violanti (1997:120) and Tull (2010:3) acknowledged the powerful role of support group members in dealing with trauma. The sharing of experiences about same problems, similar characteristics, lifestyles and attitude promotes group solidarity, being there for each other and learning how others overcame the effects of a traumatic experience, thereby reducing the effect of trauma in the support group members’ lives (Violanti 1997:120).

According to Grinage (2003:2408), support groups are important initial interventions that engage survivors of trauma to help mitigate the impact of the traumatic event. Local and national support groups may help to destigmatise the mental health diagnosis. They may also assist to reaffirm that the symptoms of trauma involve more than just a reaction to normal stress and that these reactions require more attention, such as adhering to treatment. Group work with trauma survivors provides an environment in which individuals can realise their own potential for self-healing, which can lead to enhanced autonomy and self-regard (Ahmed 2007:373).

#### *2.17.1.3.4 Encouraging adherence to treatment and ensuring commitment to support group programmes*

Employees on psychiatric treatment for PTSD and those on other programmes such as PTSD support groups need to be encouraged to regularly attend the sessions and take medical treatment as prescribed. A regular attendance and consumption of prescribed medications prevents relapses (Yehuda 2002:112).

#### *2.17.1.3.5 Encouraging social support among the SAPS workers in managing PTSD*

Social support is one of the crucial necessities essential for physical and psychological health, especially after being exposed to trauma (Klaric et al 2008:466; Ozbay, Johnson, Dimoulas, Morgan, Charney & Southwick 2007:35; Gumani 2012:132). Social interactions and support from family, friends, colleagues and significant others provide individuals with social assistance, love and care that would be readily available in times of need and protects against development of trauma-related pathology (Kaniasty 2005:1; Emmelkamp, Komproe, Van Ommeren & Schagen 2002:146; Macritchie 2006:136; Pfeifer 2011:18; Louw et al 2010:1; Kaniasty 2005:1; Robinaugh, Margues, Traeger, Marks, Sung, Beck & Pollack 2011:1072; Macauley 2011:1; Dyregrov 2003:24; Klaric et al 2008:466). Social support also enhances trauma resilience and recovery (Ozbay et al 2007:36).

#### *2.17.1.3.6 Multiple stressor debriefing and support sessions*

Counseling within the SAPS organisation also takes the form of long-term trauma interventions, also known as multiple stressor debriefing programs. These programmes focus mainly on identified “high risk units” within the SAPS organisation that are considered to be constantly exposed to trauma than other SAPS units. They include the Criminal Record Centre (CRC), Family Violence, Child Protection and Sexual Offences (FCS) and the Detectives (The SAPS EHW marketing pamphlet 2010:1).

#### *2.17.1.3.7 THE SAPS EHW call Centre*

The EHW call Centre is also available for employees to receive confidential counseling as well as case referral system, should there be a need for further interventions (Minister of police report 2013 April 16). Reactive support services such as counseling and therapy are available to SAPS workers and their immediate families. These services can be accessed while on duty. The EHW professionals are available on a 24

hour-seven days a week confidential National call center and also on a standby call line at cluster police stations to attend to any crisis or traumatic incidents and to provide required support (Minister of police report 2013 April 16; Mabe 2004:10).

#### *2.17.1.3.8 The SAPS' Employee Health and Wellness Programme (EHWP)*

According to Rajin (2012:1), Employee Assistance Programmes (EAP's), also called Employee Health and Wellness Programmes (EHWP's), support employees with the provision of employee wellness and creation of a working environment conducive to an effective and efficient delivery of police services. The author further posited that EHWP's have been proven to be valuable as skilled and high performing workers who are troubled can receive professional assistance with regard to financial, personal, marital, work-related stress, substance dependency and abuse, anxiety, depression and relationship problems. Thus, EHW services identify and eradicate the root causes of the problems experienced by workers thereby reducing problems such as absenteeism, workplace accidents and grievances. These services are rendered within the work environment and once the workers can effectively manage these challenges and problems, they become more productive and more employers could benefit from the EHWP (Rajin 2012:1).

In a nutshell, the Employee Health and Wellness programme within the SAPS adopted an in-house type of EAP/EHW model. With this model (Rajin 2012:21), professional diagnosis and treatment services are provided within an institution. Thus, the employer provides a full professional EAP/EHW service by employing practitioners on a fulltime basis. It is an integrated approach that utilises psychologists, social workers, psychometrists, and chaplains to provide support and assistance to the SAPS workers and their immediate family members (Mofamere 2003:18; The police Minister report 2010:1; Chetty 2011:4; The police Minister report 2013 April 16; Mabe 2004:10).

Studies conducted in the SAPS organisation, specifically on spiritual services, include one by (Mofamere 2003:19), which echoed that spiritual services offered by the SAPS chaplains, are there for the religious support of the SAPS workers in the work environment. Such services ensure that workers are spiritually empowered and cared for by executing a ministry that promotes spiritual growth and sustains the ethos of high morality and ethical credibility (Mofamere 2003:19).

A study by Joubert et al (2013:1) determined the extent to which the SAPS workers participated in religion and their opinion regarding the value religion added to their lives. Most (87%), of the study participants in Joubert et al (2013:1) indicated that the SAPS spiritual services have a vital role to play in supporting the SAPS workforce in fighting against crime. This underscores that the presence of chaplains in the work environment fills a “religious vacuum” through devotional and spiritual counseling sessions, leading to feelings of being spiritually cared for by the SAPS organisation, thus enhancing workers’ wellbeing and performance.

#### *2.17.1.3.9 EHWP’s integrated approach to assisting SAPS workers and their immediate family members*

The integrated SAPS EHW programmes include HIV/AIDS and support groups, trauma counseling and management, police day events, suicide prevention (choose life) campaigns, information, education and communication programmes on healthy lifestyles and marriage enrichment. The three health professions within the SAPS organisation, namely Psychological, Social and Spiritual services personnel, thus assist in ensuring employee health and wellness (The police Minister report 2013 April 16). SAPS members attend pro-active programmes presented by EHW practitioners based on identified needs and the programmes are prioritised from recurring themes and trends (The police Minister report 2010:1).

#### *2.17.1.3.10 Integration of the SAPS EHWP with external mental and health resources*

The integration of the SAPS EHWP also involves constant liaison with external professionals such as specialist psychiatrists; Health risk managers, medical doctors, psychologists, Non-Governmental Organisations (NGO’s) such as Life-line, Soul City, Crisis Center, Families counseling centers and relevant governmental departments. This integrative liaison establishes partnerships of open communication and understanding as these organisations regularly serve members of the SAPS and their families (The police Minister report 2010:1; The police Minister report 2013, April 16).

The SAPS organisation’s three components, namely social, psychological and spiritual services form a unit of EHWP. The SAPS organisation’s in-house model allows for flexibility. It refers members to outside resources such as psychologists, psychiatrists, medical doctors, and to other NGO’s for further specialised treatment and support as per identified need. The SAPS workers, therefore, utilise funds from the POLMED



scheme or make cash payments for services rendered by external health resources (The police Minister report 2013 April 16).

## **2.18 BENEFITS OF WORKPLACE TRAUMA INTERVENTIONS AND SUPPORT PROGRAMMES**

### **2.18.1 Improved quality of life**

PTSD can have an adverse effect on a person's life. Effective management is crucial as it leads to improved quality of life for trauma survivors. Thus, there is a need for psychological support after a police worker has experienced a traumatic incident (Tull 2010:1). The author further states that by seeking to effectively deal with work-related trauma, the employer reflects a humanitarian concern for fellow human beings.

Furthermore, a work force that feels secure and well catered for is likely to be productive. The employer, in such a situation, reflects legal responsibility of a duty to care, as enshrined in both common and statute law: the Occupational Health and Safety Act (OHSA); which states that "It should be the duty and responsibility of every employer to ensure so far as reasonably practicable, the health, safety and welfare of all its employees". By so doing the organisation also acknowledges the impact of trauma on the individual worker and on the organisation, thus providing a supportive environment of normalising the effect that trauma has on police workers and giving permission for police workers to take care of their wellbeing (Bell, Kulkani & Dalton 2003:466; Tehrani 2004:36; Maabela 2011:16; Tehrani 2011:117).

A supportive environment allows for worker's vacations and rest periods, and creates opportunities for police workers to vary their workload and work activities, participate in continuing education and develop and make time for other self-care activities (Bell et al 2003:46).

### **2.18.2 Decreased risk to the development of vicarious trauma**

The implementation of support and intervention work-place programmes within the SAPS organisation will curb the development of vicarious trauma or secondary trauma. These intervention programmes also reduce emotional residue and re-traumatisation due to exposure to trauma of various forms, including pain, fear; and terror that the SAPS workers, including the professionals from the EHW often encounter. Chaplains, social workers, psychologists and psychometrists deal with and empathise with

traumatised clients and community members who are victims of violence and abuse, thus reducing the chances for the development of vicarious trauma (Tehrani 2011:101; Macritchie 2006:8; Van Lelyveld 2008:1; Jonas 2003:4; Pillay 2008:39; Gumani 2012:423; Silver, Portnoy & Peters 2004:854; Bell et al 2003:464; APA 2013:2).

Working with victims of trauma has been found to have both positive and negative effects on workers. On a positive note, it leads to a sense of connection with others, and increases feelings of self-esteem after helping victims regain a sense of wholeness, meaning and control of their lives. However, the reality is that there are also negative effects including feelings of blame and helplessness in protecting clients and keeping them safe, and feeling authentically worried about client situations, even after work hours (Silver et al 2006:853; Macritchie 2006:17).

A quantitative study by Van Leyveld (2008:1) aimed at determining the prevalence of vicarious trauma within the SAPS organisation, evaluated how rank, marital status, level of education, duration of service, and workload affected the existence of vicarious trauma and its effects on SAPS workers' lives. The study sample comprised of 60 SAPS workers from the Limpopo Province's Lebowakgomo and Mankweng police stations. Results showed the presence of high levels of vicarious trauma among the participants, with the workers' duration of service and marital status having had an influence on the vulnerability to vicarious trauma (Van Lelyveld 2008:57)

Silver et al (2006:847) assessed the effect of stress, burnout, vicarious trauma and other emotional realities in the lawyer-client relationship. The results showed that the lawyers' work exposed them to continuous trauma in the form of empathetic and compassionate engagement with traumatised clients. Thus, trauma becomes the centerpiece of, for instance divorce or refugee cases which lawyers have to engage as a critical mass of legal data and evidence (Silver et al 2006:860). Feelings of helplessness, work pressure, mental drain, dealing with expectations and demands of highly emotional clients were reported, and the lawyers indicated that they were especially traumatised by abused children as well as human rights cases (Silver et al 2006:859).

Another study conducted in the legal work environment, by Jaffe, Crooks Dunford-Jackson and Town (2003:6) investigated symptoms of vicarious trauma, coping strategies and prevention suggestions among 105 judges. The findings showed that a majority (63%) of judges reported symptoms related to work-related vicarious trauma

experiences. Female judges reported more symptoms than those with seven or more years of experience. In addition, more female judges reported difficulties in internalising traumatic symptoms while judges with more experience reported higher levels of externalising and hostility symptoms. The study yielded a multi-domain coping and prevention strategies, including personal, professional assistance and societal awareness and support for judges (Jaffe et al 2003:7).

## **2.19 CONCLUSION**

This chapter reviewed literature revolving around the research objectives. It discussed an outline of trauma and PTSD and how they impact on various facets of life, on the SAPS as an organisation and on the SAPS workers and their immediate families. It also highlighted the epidemiology, incidence and prevalence of PTSD among the SAPS workforce, and other international countries. The chapter also highlighted PTSD legislation and available SAPS workplace support structures and programmes and finally reported on the compensation that can be accessed for disablement due to PTSD

Chapter 3 discusses the theoretical framework used in the current study.

## **CHAPTER 3**

### **CONCEPTUAL FRAMEWORK**

#### **3.1 INTRODUCTION**

This chapter discusses the Wits Trauma Model (WTM) that underpinned and provided grounding for the current study. According to the encyclopedia and Dictionary of Medicine, Nursing, and Allied Health (2003:1), a conceptual framework is an organization of concepts that provides a focus for research. The chapter, thus, introduces and describes the model that provided justification for the existence of the research problem investigated in this study.

#### **3.2 THE WITS TRAUMA MODEL**

The WTM was developed by Eagle, Friedman and Shumkler, from the Psychology Department of the University of Witwatersrand (WITS), in 1993 (Bean 2008:22). The model was developed out of an amalgam of theoretically informed approaches and clinical experience in treating traumatic stress conditions in South Africa (Bean 2008:22).

Archival trauma case-based data was used as the basis for constructing thematically selective case narratives that demonstrated the application of the model. The trauma data also illustrated the operationalisation of the principles of the model in treating trauma and PTSD within the South African context (Bean 2008:22).

The WTM provided grounding for the current study due to its integrative nature, which acknowledges that trauma impacts on the person's internal (cognitive) and external (behavioral) psychological functioning (Hajiyiannis & Robertson 1999:4). Therefore, the condition requires a treatment approach which addresses internal, psychodynamic processes, and an intervention which is structured and problem oriented to address the external impact of trauma. The cognitive-behavioral approach aims at facilitating the development of coping skills and supporting the individual to identify and correct cognitive falsifications and ascriptions of meaning from the traumatic experience (Hajiyiannis et al 1998:4).

Furthermore, integrative approaches facilitate the assimilation of the trauma and prevent the use of repression as a defense strategy (Hajiyiannis et al 1999:4). Integrative approaches incorporate the core components of interventions identified from various models of health care. These include techniques originating within both the psychodynamic and cognitive-behavioral approaches (Hajiyiannis et al 1999:4). The model directs intervention at specific dimensions of traumatic stress through placing a strong focus on either cognitive features or exposure elements and anxiety management or psychodynamic elements. Thus psychodynamic and cognitive-behavioral processes interact to influence development, maintenance and prevention of PTSD (Hajiyiannis et al 1999:4).

The philosophy of the WTM underscores that it is crucial to recognize both the cognitive and behavioral impact of trauma in order to comprehensively address the client's distress in facilitating the trauma management process. The WTM offers effective trauma management tools necessary to addressing subjective elements of trauma and PTSD (Sibisi 1999:12). An effective trauma management programme is necessary, specifically in the context of the SAPS organization, where workers experience continuous exposure to trauma, and require a comprehensive approach to effectively manage the impact thereof.

### **3.3 JUSTIFICATION FOR CHOOSING THE WITS TRAUMA MODEL**

The WTM was selected for this study as its components facilitated the formulation of intervention guidelines for managing trauma and PTSD in the context of the SAPS organization due to its comprehensiveness and clear structure towards addressing most of the trauma survivor's individual and unique needs and concerns. Its comprehensiveness enables ease of use by both qualified mental health professionals and apprentice counselors. The model also allows individual counselors/debriefers to integrate various therapeutic and counseling styles with differing theoretical orientations, education and training (Hajiyiannis et al 1998:8).

Each individual client, within the SAPS workforce, presents unique traumatic experiences. The use of the WTM is envisaged to cater for all distinctive trauma cases, and will be used with ease by all trained trauma debriefers, health and mental professionals within the SAPS organization due to its flexibility and all-inclusiveness.

The use is envisaged as leading to a positive contribution to the effective management of PTSD within the SAPS workforce.

The WTM's usefulness was noted in diverse cases of historical, complex, multiple and uncomplicated trauma in which clients were functional but only temporarily disorganized due to the traumatic experiences (Hajiyiannis et al 1998:8). The WTM fitted well within the context of the SAPS workforce as workers indeed present with various types of trauma and PTSD.

The WTM is effective with both men and women of different age groups who are from diverse cultural and socio-economic backgrounds. Thus, the diverse SAPS community, where workers come from various backgrounds and different demographics, will benefit from the WTM.

The WTM uses a psychodynamic approach aiming at locating the impact of trauma within the person's historical context (Bean 2008:13). The SAPS workers are continuously exposed to the same traumatic incidents on a daily basis and possibly for the rest of their career within the SAPS organization. Therefore, the WTM will assist in dealing with and managing similar historical and previously experienced trauma for the SAPS workers.

In a nutshell, the philosophy of the WTM states that clients need not be sophisticated or psychologically minded to benefit from it (Hajiyiannis et al 1998:9). Most of the SAPS workers in the current study had below Matric; some had Matric while a few had post-Matric qualifications. Their educational level will, as noted in the model, not impede the SAPS workers' benefit.

After obtaining training on the WTM processes, trauma debriefers, counselors and therapists within the SAPS workforce will be much empowered and in a position to integrate the use of the EMDR trauma and PTSD management strategy in supporting traumatised workers and those diagnosed with work and non-related PTSD. This is due to the fact that the model has been scientifically proven to successfully integrate this trauma management technique (Hajiyiannis et al 1998:9). Tehrani (2004:93) affirmed that the EMDR procedure has been found to be effective in managing PTSD.

Positive outcomes experienced with the use of the WTM include improvement in clients' mood and concentration, ability to resume previous levels of functioning without

presenting new symptoms and the ability to process more about traumatic experiences through retelling the traumatic event (Sibisi 1999:9). Generating effective coping mechanisms is essential within the SAPS work environment, as police work is psychologically and physically demanding. Ability to manage trauma symptoms is envisaged to restore the SAPS worker's morale, thus, ultimately leading to fully functional workers.

According to Sibisi (1999:72), the client's ability to develop new convictions, meaning and direction in life, normally yields positive outcomes, such as enhanced self-management and restored feelings of competence. Further benefits include an ability to understand and have greater insight in approaching the world in a more realistic and manageable way, having a sense of enriched appreciation of present and future lives, and feelings of relief and healing. The ability to create cognitively consistent structures around traumatic events, in context and in the past, is mostly achieved with the use of the WTM. These are fundamental coping mechanisms the SAPS workers require in their daily work (Sibisi 1999:72).

The choice of this model was not by fault, but by appropriate reflection of its immense input to effective trauma management. The model was chosen specifically on the recognition of very real impact of trauma on the person's mind and subsequently on their behavior. Young (2005:60) observed that the SAPS workers' constant exposure to trauma brings about mixed perceptions and feelings about their work as well as about life in general. Therefore, the workers' ability to recognise support rendered by the SAPS organisation through adoption and implementation of the WTM is envisaged to bring about feelings of appreciation, as well as enable the processing of traumatic experiences in a safe and supportive environment. This is highly likely to produce reinforced optimism, assertiveness, confidence, job fulfillment and efficacy among the SAPS service workers.

### **3.4 USING AN INTEGRATIVE APPROACH TO MANAGE PTSD**

Early psychological intervention in the form of cognitive-behavior counseling and trauma debriefing offers traumatised individuals an opportunity for catharsis and enables workers to recognise and appreciate peer and organisational support which is critical for effective trauma recovery and management (Sibisi 1999:7).

According to Leibowitz-Levy (2005:155), integrative approaches are highly recommended for the treatment of PTSD within the South African context. This is due to the fact that South Africa is different from other international countries such as England and the United States of America (USA) in terms of the nature and frequency of traumatic incidents experienced by the citizenry (Leibowitz-Levy 2005:155).

A high prevalence rate of trauma due to high levels of violence and crime in South Africa (SA) leads to an enormous demand for trauma counseling and trauma management services (De Beer 2012:1, Pienaar et al 2005:58, Chabalala 2005:4; Williams et al 2007:845). As a result, WTM was developed based on observations and experience gathered from the South African environment as well as from the client case material based on various forms of post-traumatic stress (Hajiyiannis et al 1999:4).

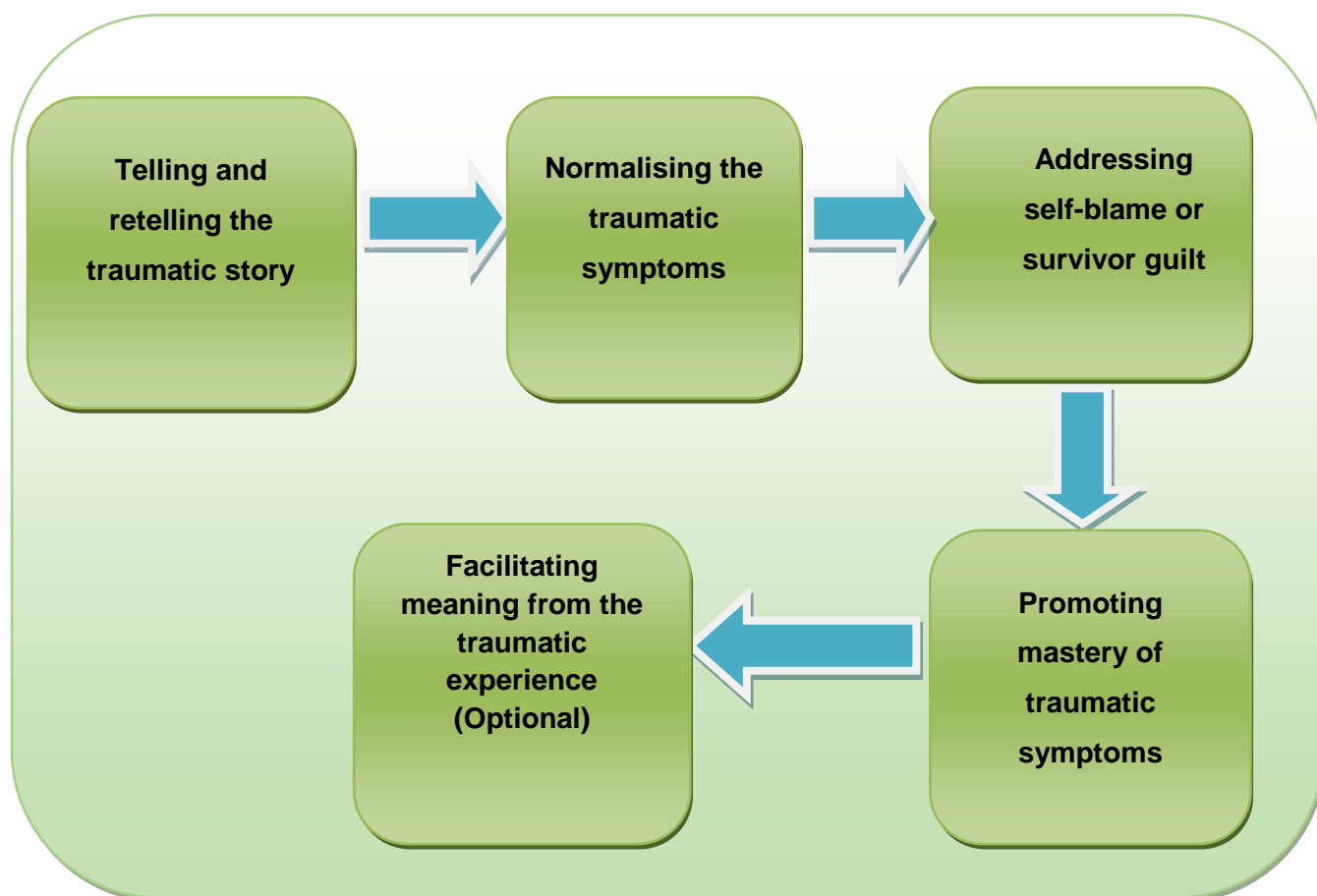
### **3.5 COMPONENTS OF THE WITS TRAUMA MODEL**

In promoting recovery from trauma and management of PTSD, the WTM employs five treatment goals, which also form part of the components of the model (Eagle 1998:138). The components illustrate an integration of both psychodynamic and cognitive-behavioral approaches to managing trauma and PTSD in SA (Edwards 2009:189, Sibisi 1999:11 & Hajiyiannis et al 1999:4). These components can be used interchangeably depending on the circumstances, specifically the needs of the client and the natural flow of trauma counseling and debriefing sessions (Eagle 1998:138). The components are:

- Telling/retelling the traumatic story
- Normalising the traumatic symptoms
- Addressing survivor guilt or self-blame
- Promoting mastery of traumatic symptoms
- Facilitating creation of meaning from the traumatic experience



Figure 3.1 shows a diagrammatical presentation of the WTM.



**Figure 3.1: Diagrammatical representation of the Wits Trauma Model**

(Adapted from Eagle 1998:138)

The above figure shows the process followed using the WTM in an effort to assist trauma survivors to effectively manage the effects thereof. The five goals of the WTM, described in line with the study objectives are presented below:

### **3.5.1 Telling and retelling the traumatic story**

Giving a detailed description of the traumatic incident in sequence, reflecting the facts, feelings, thoughts, sensations and cognitions, most importantly imagined or fantasised aspects of the traumatic event, is the main focus during this stage (Eagle 1998:139). An adaptive inhibition of traumatic reactions normally happens during life threatening situations. It is therefore important to encourage clients to express the often unexpressed feelings and fantasies connected to trauma in a safe therapeutic environment. The prevention of repression and displacement of feelings and fantasies

into other symptoms is ensured at this stage. The client's ability to impose a time sequence onto the event, transforming sensory and episodic memories to the realm of processed thought and symbolism is also ascertained at this stage (Eagle 1998:139).

In psychologically accompanying the client through the traumatic event, the client is able to demonstrate his/her ability to tolerate horrific or overwhelming aspects of the trauma. This serves as a positive model to clients when the memory is evoked in the future. At this stage, the counselor encourages confrontation rather than avoidance of aversive stimuli, which serves to reduce anticipated anxiety associated with the stimulus (Eagle 1998:139). This includes repressed traumatic experiences which were never verbalised in a counseling setting. The main goal of this psychodynamic approach is also to facilitate an integration of the trauma and to prevent using repression as a defense mechanism (Bean 2008:13).

Anxiety and a sense of confusion are often present after trauma (Eagle 1998:140). The physical presence of a trauma counselor/debriefer, the trauma counselor's active listening, empathetic reflection and appropriate questioning are crucial during this phase as it serves as a source of protection and anxiety reduction (Eagle 1998:140). Imaginary rather than the in vivo nature of exposure allows for gradual tolerance of the anxiety provoking material. Cognitively, detailed story telling allows for the creation of some cognitive structure around the traumatic event. This leads to the process of assimilation and accommodation of the traumatic event into the existing cognitive framework being facilitated (Eagle 1998:140).

Encouraging clients and making them aware of the benefits of talking about traumatic experiences offers a useful opportunity to ventilate (Tehrani 2011:17). It also serves as a realisation process that talking about trauma is a supportive occupational health intervention tool, as historical trauma memories shall be managed. Bringing the traumatic experiences, thoughts and effects to the surface, is helpful in modifying irrational and childlike thinking experienced by trauma survivors. This allows for logical communication of thought material, which in turn facilitates the internalisation of such irrational constructs (Eagle 1998:139).

### **3.5.2 Normalising the traumatic symptoms**

The emphasis of this component comprises of the trauma counselor/debriefer obtaining as much information about the traumatic symptoms experienced by the client. The

client's symptoms are discussed in detail and the client is empathised with. The counselor also informs the police worker about what other symptoms to expect. This serves to reduce fear and any views that the client is falling into a mental breakdown as well as to reduce the chances of a client suffering secondary traumatisation due to the fear of their symptoms. The anticipation of the symptoms and their understanding leads to greater tolerance and symptom reduction. Thus, the provision of education about post-traumatic stress symptoms is crucial during this phase (Eagle 1998:140).

Given the nature of work exposing them to continuous traumatic incidents of similar and varying types, the SAPS workers shall be empowered on how to effectively manage trauma. This means that the workers' anticipation and education about the symptoms is will bring about a sense of normalcy as they would be informed and mentally prepared prior to exposure.

During this stage, a link is made between the traumatic event itself and symptoms experienced, as well as a reassurance of the normalcy of experiencing such symptoms as outlined earlier on. The trauma counselor/debriefer reassures the client of the normalcy of their responses, which are normal reactions to abnormal situations, and highlight the expectancy of the reactions diminishing in time, especially after receiving trauma counseling (Eagle 1998:140). This component of the WTM is mainly psycho-educational, and falls within the sphere of cognitive-behavioral intervention (Eagle 1998:140).

### **3.5.3 Addressing self-blame or survivor guilt**

Self-blame and guilt feelings are always present in trauma survivors (Eagle 1998:141). Self-blame is related to a retrospective wish to "undo" trauma and provide the survivor with some greater sense of agency, particularly in anticipating such encounters in the future. The psychological impact of self-blame is always detrimental to self-esteem; therefore, there is need for an effective management of these feelings (Eagle 1998:141).

Interventions to address feelings of self-blame by trauma survivors may vary. The main goal here is to attain self-respect (Eagle 1998:141). Guided imagery enactment of preferred traumatic scenarios can be useful to assist the client to process experienced self-blame and guilt feelings. During this stage, clients are encouraged to develop their own guided insights; so as to be released from self-criticism. Clients may also be

encouraged to take a third-person position in relation to assessing their actions, counteracting judgments imposed by significant others, reinforcing the fact that their actions facilitated their survival, and emphasising that asserting their judgment in the situation was the only valid way to respond (Eagle 1998:141).

In addressing survivor guilt or self-blame, the counselor reassures the client of their best performance under the experienced circumstances. This also reinforces the fact that their actions facilitated their survival. It addresses the clients' concerns on how their actions affected others and also explores irrational beliefs that may have developed (Hajiyiannis et al 1999:6).

Reinforcing any behaviors, thoughts or strategies which were effective or indicative of some mastery during the traumatic situation may assist the client to restore a sense of control and self-respect. This may also enable the client to reconcile themselves with the reality of what happened and their role without damaging their self-concept. This component helps to bring a conscious awareness of any doubts about self-efficacy as well as blame (Eagle 1998:141).

### **3.5.4 Promoting mastery of traumatic symptoms**

During this stage, the trauma counselor/ debriefer assists the client to carry on with tasks of daily living and to restore their previous levels of coping (Eagle 1998:142). One of the most important aspects of coping is to encourage the client to establish and maintain adequate support in the form of friends and family members (Pfeifer 2011:18; Macauley 2011:1).

The support system plays a fundamental role in assisting with needs such as ensuring compliance and adherence to medical treatment, observing any new symptoms and keeping regular contact with the client's health professionals. It also includes crucial aspects such as reminding and accompanying the client to doctor's follow up consultations, ensuring that the client maintains a healthy diet and accompanying and engaging the client in day-to-day recreational, family and social activities (Eagle 1998:142). Mobilisation and maintenance of family and friends support is actually identified as essential in encouraging the client to complete homework-type tasks assigned by the trauma counselor/debriefer and to realise the importance of ventilation about traumatic incidents with their confidante, as is also recommended during this phase (Eagle 1998:142).

Feelings of helplessness are normally experienced by trauma survivors (Eagle 1998:142). This component is not only designed to assist the client to counteract feelings of helplessness associated with the trauma but also to deal with the ensuing symptoms of self-blame and guilt. Mastery of traumatic symptoms is enhanced in part by each person's behavior and progress in dealing with their self-blame and guilt feelings during the third phase of the WTM (Eagle 1998:142).

Education and creating an awareness of the negative impact of maladaptive coping strategies is at play during this stage. Ineffective coping mechanisms such as avoidance, rumination about the trauma, "splitting", (a pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation (DSM-IV: 1), acting out, as well as substance abuse are discussed and discouraged (Smith 2006:28). Psycho-education with regards to experienced stress reactions and on integrating other cognitive-behavioral strategies to PTSD management such as behavior psychotherapy and behavior rehearsal which are useful in modifying and improving fundamental interpersonal skills and social interactions emphasising on getting the person to behave differently (Stratton & Hayes 1999:30) is at play during this stage of the WTM (Eagle 1998:142).

According to Eagle (1998:142), behavior rehearsals are useful in dealing with social withdrawal, self-blame and guilt feelings normally experienced after trauma. Progressive relaxation techniques are used by the trauma counselor to enhance both mental and physical strength, concentration as well as avoidance problems. After exposure to trauma, there is a need to regenerate physical and mental energy. The coping skills, crucial for the management of other trauma reactions, include loss of focus and curbing the use of ineffective coping strategies (Eagle 1998:142).

The trauma counselor/debriefer also uses the intervention strategy of Eye Movement Desensitisation and Reprocessing (EMDR), which enhances both anxiety reduction and management skills and is most effective for healing PTSD (Eagle 1998:142 and Tehrani 2004:93). The EMDR strategy is also used to assist the trauma survivor to develop a sense of controllability over the traumatic experience leading to a mastery that is self-reinforcing and the development of an attitude of greater optimism. Anxiety associated with trauma stimulus is also greatly reduced (Eagle 1998:143). With these cognitive-behavioral techniques, the client experiences success in mastering the impact of trauma (Eagle 1998:142).

### **3.5.5 Facilitating creation of meaning from the traumatic experience**

The final stage of the WTM is optional and only pursued by the counselor / debriefer if the client raises the need to derive meaning from the traumatic experiences (Eagle 1998:143). Being aware and alert to a client's need to derive meaning is important for the trauma counselor/debriefer. However, it is essential to avoid imposing the derivation of meaning as the process may be longer and not be achieved using brief-term therapy used with the WTM.

According to Eagle (1998:143), creation of meaning from traumatic experiences involves engaging with a person's belief system, and cultural, political, spiritual or existential levels. What is crucial here is that one must be respectful and engaging in dealing with the person's existing belief system, be it spiritual, political or cultural, in an attempt to assist them to derive some salutary meaning from the traumatic experience. This involves encouraging the client to engage with other healers, such as traditional healers and priests, whom they believe in. Engendering hope and future perspectives without denying the damage made by the traumatic incident on the person is also of great importance in helping the client to generate some form of meaning.

According to Eagle (1998:143), this component of the WTM can be understood within the frameworks developed by Klein (1960), which is the Kleinian theory and the self-psychology. Eagle (1998:143) asserts further that creating meaning from traumatic experiences using the Kleinian framework represents the person's transition from a more damaged paranoid-schizoid position (a group of anxieties, defenses, internal as well as external object relations characteristic of earliest months of an infant's life continuing to a greater extent into childhood and adulthood) into a healthier depressive position manifesting in the ability to integrate good and bad in relations with others in the world (Eagle 1998:143).

The counselor takes the client through a process that assists them to feel a sense of new wholeness in embracing "a self" that has encountered an attack and survived. This means inculcating a sense, in the client, of having been there, during trauma and having returned. During this stage, the counselor observes appreciation of present life over a future one as manifesting in clients, thus there is normally a high prevalence of a life instinct over death among clients (Eagle 1998:143).

From the Cognitive behaviorists' perspective, this phase of the WTM is mainly about facilitating the development of more complex cognitive systems which involves engaging the client in cognitive re-appraisal processes. The processes involve the client assessing personal and individual interpretation of a situation, and how they subjectively experience their environments (Online Psychology Dictionary 2013:1). With these processes, ambivalence and ambiguity can be entertained, leading to the production of more resilient schemas and positive outcomes such as the development of new convictions and directions for one's life. This is key to allowing a person to engage in positively reinforcing behaviors such as becoming a role model for others (Eagle 1998:143).

The inference drawn from both the Klienian and self-psychology frameworks is that the framework enhances a clients' ability to internalise and understand themselves as survivors rather than victims. It makes the client lives with an altered view of themselves and the world, which in a way enhances their future orientation and effective way to manage trauma and PTSD.

The WTM is used to offer counseling to victims of violence and trauma (Hajiyiannis et al 1999:1). This includes individuals who have experienced criminal, sexual political violence, traumatic bereavement, motor vehicle accidents and natural disasters (Hajiyiannis et al 1999:1).The SAPS workers operate in environments that expose them to similar traumatic incidents such as rape, hijacking, assault, sexual, emotional and physical abuse, domestic violence, loss, and car accidents. Thus, post-traumatic stress due to exposure to these kinds of incidents is treatable using the WTM.

### **3.6 CONCLUSION**

This chapter discussed the model underpinning this study. It examined the model in detail and its relevance to the focus of the current study. The WTM guided this study to address the research topic on the development of guidelines for the management of PTSD among the SAPS workers and their immediate family members in Mahikeng area. The chapter also discussed the justification for choosing the WTM model.

The next chapter discusses the research methodology used in this study.

## **CHAPTER 4**

### **RESEARCH DESIGN AND METHODS**

#### **4.1 INTRODUCTION**

This chapter discusses methods used to conduct the study, and the research design, population, sample, data collection tools and process. The chapter further presents data analysis methods and measures applied for ethical considerations.

#### **4.2 RESEARCH DESIGN**

##### **4.2.1 Research paradigm**

Creswell (2007:19) and Roux and Barry (2009:2) referred to a paradigm as a researcher's philosophical worldview or a set of assumptions, epistemologies, ideas and beliefs that guide action. The paradigm provides a fundamental link between the different research activities (Roux et al 2009:2) According to Creswell (2007:19), researchers' own beliefs contribute immensely to the research approaches adopted. Thus, qualitative, quantitative or mixed approaches may be adopted by researchers under various worldviews including pragmatism, post-positivism, advocacy/ participatory and constructivism.

In order to ensure that relevant data was obtained from study participants, a descriptive approach under the advocacy/ participatory paradigm was adopted by the researcher. With this paradigm, a health-related issue of PTSD was of paramount importance to the researcher. Therefore a marginalised group of the SAPS workers diagnosed with PTSD was studied. The results of the study were used to make recommendations and develop guidelines that will influence organisational and social change.

##### **4.2.2 Research design**

Lester (2005:21) defined a research design as "an overall plan for collecting and analysing data". In this study, a qualitative design and retrospective record reviews were used to gain an insight into the number of SAPS workers diagnosed with PTSD, on the health and social effects of PTSD on the SAPS workers and their immediate family members in Mahikeng and on the available onsite occupational health interventions for the management of workers with PTSD. Data gathered using this design was further used to develop proposed guidelines to manage PTSD within the SAPS organisation in



the Mahikeng cluster. An unstructured questionnaire with open-ended questions used in the survey focused mainly on discovering and understanding the participants' experiences, perspectives and thoughts regarding PTSD.

The use of a qualitative design and retrospective record reviews in this study was most suitable as it permitted a once-off administration of the survey instrument in order to acquire data among both groups of participants and also from the SAPS EHW National, Provincial and Mahikeng offices. Therefore the design enabled the researcher to acquire data about the effects of PTSD on the SAPS workers and their immediate family members in one study.

### **4.3 RESEARCH METHOD**

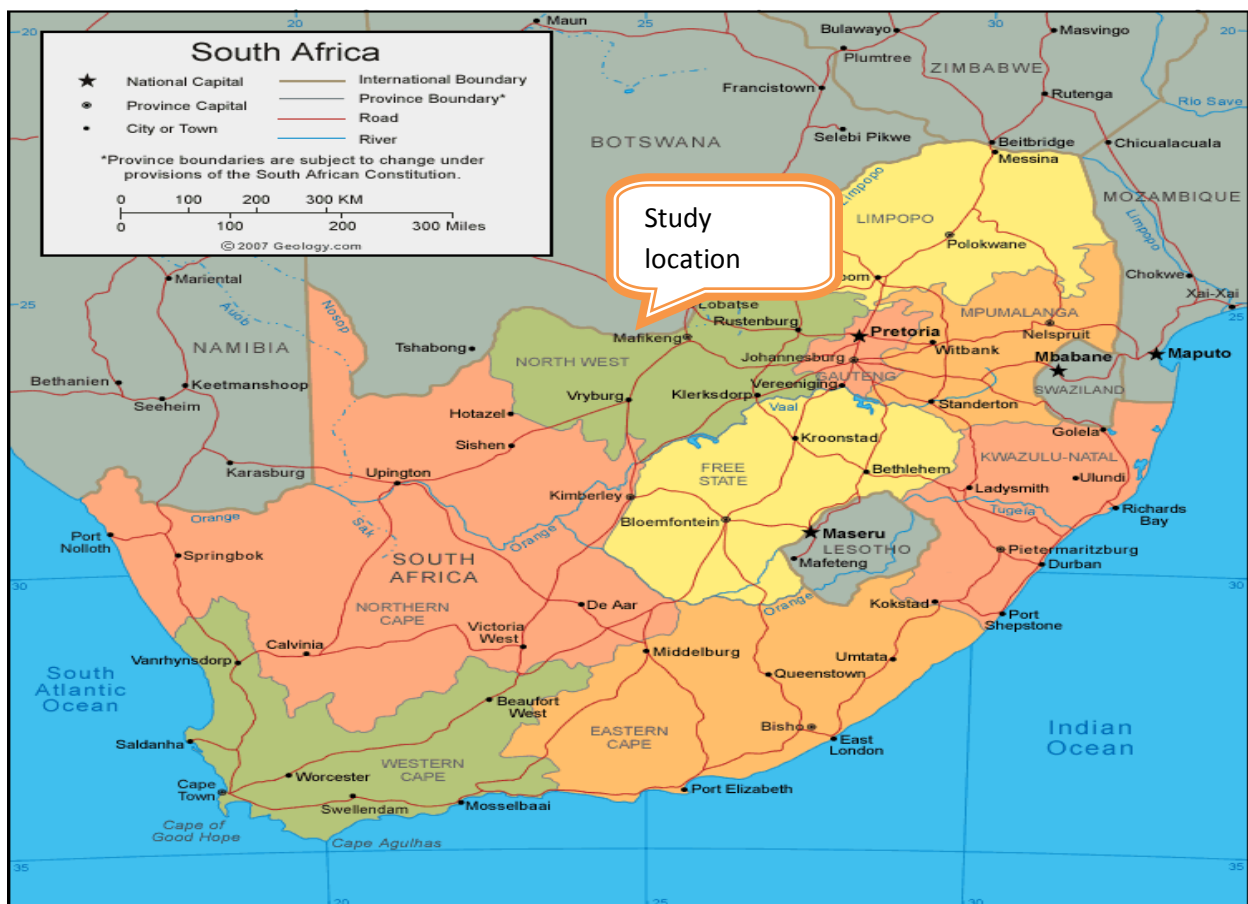
Silverman (2010:121) defined a research method as a general approach to studying research topics. The choice of method that the researcher uses reflects an overall research strategy, thus it shapes which methods and how the methods were used. In this study, a qualitative method was used. With this method, the researcher studied the extent of the prevalence of and the detailed description of the health and social effects of the phenomenon of PTSD among the SAPS workers and their immediate family members.

#### **4.3.1 Research setting**

This study was conducted at Mahikeng and surrounding areas in the Ngaka Modiri Molema District of the North West Province in South Africa, as shown in figure 4.1. Mahikeng is the original name, which changed in 1885, when the late Chief Montshiwa Tawana of the Barolong boo Ratshidi tribe allocated land to the British settlers. The British settlers could not pronounce Mahikeng and therefore changed the name to Mafeking. Subsequently the then Bophuthatswana Government renamed the place Mafikeng in 1977. The Barolong boo Ratshidi Royals campaigned for the original name of the area to be restored. The original name was then approved in February 2010 by the then Minister of Arts and Culture, Minister Lulu Xingwana to be changed back to Mahikeng. Both words, Mafikeng and Mahikeng have equal meaning, namely "place of rocks", with the main difference being just semantics, namely the use of the letter "h" instead of "f" (Mahikeng Museum: archives: 2015:1).

The police stations and units at which data was collected are classified under the SAPS Mahikeng Cluster. The SAPS Mahikeng Cluster has seven (7) police stations, namely: Mahikeng, Mmabatho, Lomanyaneng, Makgobistad, Mooifontein, Ottoshoop and Tshidilamolomo. The specialised units in Mahikeng are eleven (11) in number. They are: the Management and Information Centre (MIC), Vehicle Identification Services (VIS), Family Violence, Child Protection and Sexual Offences (FCS), Stock theft, Crime Intelligence Office (CIO), Flying Squad (also called 10111/Highway patrol), Inspectorate, Legal Services, Organised Crime, and Commercial Branch. The Mahikeng police station is, however, the one with a big staff composition within the cluster under study in this thesis.

Study participants, specifically the SAPS workers, are based at different police stations and units within the cluster.



**Figure 4.1: Area map of the research site**

(Municipal Demarcation Board: Mahikeng District Municipality, 2012:1)

## **4.4 SAMPLING PROCEDURE**

### **4.4.1 Population**

The study population comprised of SAPS workers stationed in the Mahikeng Cluster (Stations and Units) who were diagnosed with PTSD by specialist psychiatrists. The study population also extended to SAPS workers' immediate family members, such as their spouses, dependents and parents.

### **4.4.2 Sampling**

According to Wisker (2001:138), a sample is a selected and chosen group upon which the researcher carries out a study. Purposive sampling was used in this study. The purposively sampled workers were those diagnosed with PTSD and their immediate members as the study required a focus on only a specific group of subjects within the organisation, which are SAPS workers who have been diagnosed with PTSD. The study participants were what Shanton (2004:65) referred to as a "selected society".

#### ***4.2.2.1 Sampling of the SAPS workers***

The sampling was done among workers of all ranks within the SAPS organization, ranging from Reservist, Student and fully fledged Constable, Sergeant, Warrant Officer, Lieutenant, Captain, Major, Lieutenant Colonel, Colonel to Brigadier. The highest ranking officials in the Mahikeng Cluster were at the rank of Brigadier (Director Level). As a former SAPS EHW practitioner, the researcher had a data base of workers diagnosed with PTSD through formal referrals received from onsite specialist psychiatrist to whom she had rendered worker support in the form of alternative job placement and job transfers due to PTSD ill-health.

#### ***4.2.2.2 Sampling of family members***

The sampling of family members was determined by the SAPS workers' willingness to allow the researcher to gather and share information about their health condition with their immediate families as some of the SAPS workers did not disclose the exact health condition (diagnosis) to their families. Therefore, the researcher did not include other family members whom the SAPS workers did not consent to partake in the study. As a result, only family members for whom permission was granted by the SAPS worker to include in the study were consulted with and further written consent was attained from individual family members. The family members' sample comprised of the worker's

spouse and dependents at the age of 18 years and above and member's parent (either mother or father) of single SAPS workers still residing at home with their parents and siblings.

#### **4.2.2.3 Recruitment of study participants**

Data on SAPS workers diagnosed with PTSD was also confidentially obtained from EHW practitioners who are working in other sub-units of the SAPS EHW, Social Work and Spiritual Services in the Mahikeng Cluster. However, only one worker from other EHW practitioners could be accessed to partake in the study. Other EHW practitioners could not provide their clients with PTSD to partake in the study due to reasons of confidentiality, thus the researcher was aware of other 15 SAPS workers with PTSD whom the researcher could not access to form part of the study. Other workers disclosed their health condition during separate trauma debriefing sessions conducted by the researcher as a former SAPS trauma debriefer prior to conducting the study. Some of the workers were formally referred to the researcher by a local specialist psychiatrist for workplace and family support and intervention. They formed a data base of the researcher's trauma debriefing and counseling registers and were therefore recruited to partake in the study. Face to face and telephonic arrangements to meet with the researcher at her office and at their homes were made with the workers and families to recruit them to partake in the study. The recruitment process also included the researcher providing a detailed presentation of the study aims and objectives, including aspects of confidentiality to solicit the workers and families' written consent. This led to a total of 42 study participants being recruited, as outlined in table 4.1.

**Table 4.1 Recruitment of study participants (N=42)**

<b>Number of the SAPS workers</b>	<b>Number of family members</b>
19	23
<b>Total number of study participants</b>	<b>42</b>

## **4.5 DATA COLLECTION METHOD**

Unstructured questionnaires were used as data collection tools in this study.

#### **4.5.1 Developing the study questionnaire**

Data collection tool development for both groups of participants was done with the aid of the study objectives, and problem statement. The questionnaires were designed with mainly open-ended and a few close-ended questions to ensure that additional unquantifiable data, specifically aspects relating to the effects of PTSD on the workers and on immediate family member's lives were similarly accommodated. Ideas and phenomenon under scrutiny were clearly accounted for in the data collection tool. This was found to be dependable with previous successful and equivalent research projects and literature on PTSD.

#### **4.5.2 Pre-testing of study questionnaires**

Data collection instrument pre-testing was done with four SAPS workers and four immediate family members (two dependents and two spouses) who volunteered to take part after the aim of the exercise had been explained to them by the researcher. The exercise was conducted in order to assess and to explore the phrasing and clarity of the questions and concepts in the study instrument.

Experiences regarding the pilot study included an observation of a pattern of switching from Setswana to English with both groups of study participants and vice versa as they elaborated. Therefore, all Setswana responses were captured in English as the researcher was conversant with both languages. These observations further necessitated the need to develop a Setswana version of the study questionnaire, specifically for family members as all of SAPS members were able to respond to the English version. Experiences with the pilot study also assisted the researcher to make relevant modifications to the study tool. Study tool pre-testing also assisted the researcher to measure the reliability, validity, inclusivity and impartiality of the instrument. The data collected as part of the pilot study was discarded as it was exclusively meant for pre-testing the questionnaire especially that it brought into light the need to edit and modify the instrument. Subsequently this brought about a slight difference in terms of data from the pilot study and from the main study, hence the exclusion from the main study.

#### **4.6 INTERNAL AND EXTERNAL VALIDITY OF THE STUDY**

According to Silverman (2010:275), Mertler (2009:126) and Babbie et al (2003:122), a study is valid if it accurately represents the social phenomena to which it refers to. In

other words, the extent to which an empirical measure reflects the “truth” and focus or the real meaning of the concept under consideration.

#### **4.6.1 Content validity**

According to Babbie et al (2003:123) content validity refers to how much a measure covers a range of meanings included within a concept. Prior to developing the data collection instrument, the researcher reviewed a wide range of literature on PTSD and the approaches used to collect data and various models on trauma and PTSD management. Confidential consultations were conducted with specialist psychiatrists and clinical psychologists in and outside of the Mahikeng area. This was done to gather information on PTSD which was specific to the SAPS workers in Mahikeng, which was to be included as content. Furthermore, this was done to request for referrals and to recruit and obtain data on other SAPS workers in Mahikeng diagnosed with PTSD whom the researcher was not familiar with so that they be included in the study. Prior informal surveys conducted with police workers who shared their exposure to extreme types of trauma and consultation made with trauma experts within the SAPS EHW office at national, provincial and local offices gave the researcher an insight into possible content to include in the tool. The researcher’s own experience of the traumatic nature of police work and consultation with workers diagnosed with PTSD enriched the content of the instrument. Furthermore, the researcher ensured that the content of the tool covered the concept of PTSD and a range of closely related aspects such as trauma as well as the inclusion of the SAPS workers’ family members as study participants. In ensuring that all scopes relating to the study topic were covered, the instrument was subjected to a comprehensive examination by experts in the field and the study supervisor.

#### **4.6.2 Construct validity**

It refers to the degree to which inferences can legitimately be made from the operationalization of a study to the theoretical construction which that operationalization was based. Construct validity is therefore based on the logical relationships among variables (Trochim 2006:5; Babbie et al 2003:123). In this study construct validity was ensured by not deviating from concepts related to PTSD and making reference to the legislated PTSD diagnosis documents, including the DSM-IV-TR and the Department of Labor’s Circular Instruction no 172-PTSD in developing the study instrument.

Furthermore, the construction of the data collection instrument was guided by the results arising from consulting a wide range of literature on similar studies as well as engaging various research experts in the field of trauma and PTSD (including the promoters of the study) who ensured that the variables and concepts under study were properly operationalized and not deviated from. The usage of services of a professional language editor and translator ensured construct validity for the study. Existing assessment tools for PTSD and its effects could not be used in this study due to the unique nature of the SAPS organization and the unique traumatic events the workers get exposed to, as compared to that of the general public. The study sought to identify available onsite occupational health and support services provided to the SAPS workers and immediate family members to deal with PTSD in Mahikeng. The existing assessment tools did not provide for this construct to be measured; hence the researcher developed a tool to cover this aspect. Furthermore the inclusion of family members in the study called for the development of a tool that captures specific health and social effects, and for the tool to yield data on recommendations for effective PTSD management by both groups of participants, which would assist in the development of guidelines.

#### **4.6.3 Reliability**

Reliability refers to the degree of consistency with which instances are assigned to the same category by different observers or by the same observer on different, repeated occasions (Silverman 2010:275; Babbie et al 2003:119). In this study, reliability was ensured by employing various strategies. Firstly, a relevant study design was carefully chosen, discussed, scrutinized and approved by the study promoters. Furthermore, the sample for this study represented the target population and made inclusion of the SAPS workers' immediate family members. Prior to the data collection process, all necessary precautions were ensured, such as having health and mental professionals on standby for necessary study participants' support, given the sensitive nature of the study.

According to Babbie et al (2003:122), another way of obtaining information from people is to utilise measures that have proven their reliability in previous research, thus using established measures. In this study, the data collection tool utilised (In-depth interview questionnaire) was reviewed in literature and has been found to be reliable. The data collection instrument was also subjected to a pre-testing process in order to ensure that it was objective, unbiased and that there was clarity and practice on researched

constructs so as to avoid any ambiguities. With the training and research experience that the researcher had, the researcher conducted in-depth interviews herself and avoided data omissions or incomplete data collection. Replication of collected information was also avoided at all times by the researcher. All participants were requested to be honest in their responses in order to gather objective responses and to minimize subjectivity.

#### **4.7 DATA COLLECTION PROCESS**

The data collection period for the study was six months. The process began on the 30<sup>th</sup> March 2012 and ended on the 11<sup>th</sup> September 2012. The process involved the following aspects:

##### **4.7.1 Data collected from the SAPS workers with PTSD**

Data was collected using in-depth interviews. Data collection, for most of the SAPS workers, was conducted after working hours and during week-ends at the former researcher's office space in Mahikeng, where there was minimal distraction. Most of the sessions were held with SAPS workers after work and during weekends as the researcher was always alert to the need for the research data collection process not interfering with the organization's service delivery.

##### **4.7.2 Data sourced from local referring specialist psychiatrist and staff records**

Data gathering was also done from the local specialist psychiatrist who referred workers to the researcher for workplace and family support and intervention. Furthermore, a retrospective review staff records was carried out in order to solicit relevant statistical data on SAPS workers who were diagnosed with PTSD for the period of 1995 to 2011. The information was confidentially retrieved from available staff leave records from the office of Human Resource Management i.e. statistics on sick leave, short-term and long-term incapacity leave, ill health retirement and compensation at station and provincial levels. This information was obtained in the form of electronic and hard copies. A total of 15 records were obtained through the psychiatrist and staff record reviews for workers based at various work sites in the Mahikeng cluster, including Mmabatho, Makgobistad, Lomanyaneng, Ottoshoop, Mooifontein, Mahikeng and Tshidilamolomo police stations. The specialised units included the FCS, Crime intelligence, Flying Squad and Organised Crime.



Information on the provincial statistics for SAPS workers who have been diagnosed with PTSD, those who retired on medical grounds, specifically due to PTSD, and those who were compensated for being diagnosed with PTSD was also obtained from the Provincial and National/ Head offices, Personnel Services, Ill health Retirement and Employee Life Cycle Management, Occupational injuries and Compensation offices. The obtained statistical data from both sources was mainly used to recruit participants to partake in the study and to highlight PTSD trend in the North West Province. The statistical data was for the period 2005-2012.

#### **4.7.3 Data collected from family members of SAPS workers diagnosed with PTSD**

Data from all family members was gathered at their various homes. Data collection was done after working hours and during week-ends as most family members were unavailable during the week working hours due to work and school commitments. Written consent was administered to participants upon verbal agreement to partake. Consent was also obtained from parents for children at the age of 18 and above. The following were experienced with the actual data collection process: The fact that PTSD is not often “talked” about in most people’s daily conversations, especially with family members as is the case with words such as “stress” and “depression”. Thus, most people would generalise and regard most psychological or psychiatric health conditions as “stress” and “depression” and PTSD seem to be a medical term, which is mostly used by medical professionals, and most family members generalised PTSD as serious stress and as depression.

Postponements of interview sessions were experienced due to unforeseen circumstances on the part of both groups of participants. Minimal distractions were also experienced during interviews.

#### **4.7.4 Participants’ biographical data and close-ended questionnaire data: Section A**

Study questionnaires for both groups of participants consisted of the section which gathered data on the participants’ socio-demographical data. The data gave a summary of the sample in terms of their demographics and was used for descriptive purposes only. The questions in this section were aimed at gathering data on the participants’ age, gender, marital status, ethnicity, home language, educational qualifications and

religion. The SAPS workers' questionnaire included extra information on organisational particulars such as years of service in the SAPS and rank. The organisational information was used in comparison with the studied construct of PTSD in the data analysis section of the study. Both questionnaires consisted of few close-ended questions regarding PTSD.

#### **4.7.5 Open-ended questionnaire data: Section B:**

Data collected from section B of the study questionnaire focused on the health condition itself, PTSD and its diagnosis. The questions in this section were mainly open-ended to allow participants to elaborate more on different aspects relating to the health and social effects of PTSD.

##### **(a) The SAPS workers**

Data collected under section B of the study questionnaire for SAPS workers related to PTSD diagnosis. Thus, participants were asked to share detailed data regarding their work in the SAPS organization. This included their key performance areas when got diagnosed with PTSD, symptoms experienced, professional programme they were on in relation to their health condition. This data gave more insight on the nature of work done, the possible effects experienced and on available professional support. Detailed data on what traumatic incident/s they got exposed to, and whether the incident/s was work or non-work related was gathered. Exposure to the traumatic incidents was linked to possible PTSD development. Additional questions were asked under this section regarding the effect of PTSD on the SAPS worker's health and social lives and how they were managing the effects.

An assessment of whether participants have attended trauma debriefing services offered by the SAPS EHW as a trauma management programme was done. Reasons for non-attendance of debriefing sessions were also explored. This allowed for assessment of how informed the participants were with regard to available onsite occupational health and support programmes. The last part of this section gathered information on the participants' opinions and recommendations for PTSD management.

**(b) The SAPS workers' immediate family members (spouse, dependents and parents)**

Family members provided detailed data regarding the health condition of their spouses/fathers/mothers/parents. Data on awareness about the health condition and the effects on family relations experienced in relation to living with a member diagnosed with PTSD and the roles played in supporting the SAPS worker were also explored. The feelings, reactions and challenges brought about by living with a member diagnosed with PTSD and means of coping with the condition were also discovered. Family members were also asked about whether they were receiving any form of professional assistance; furthermore family members' opinions and recommendations on how to manage living with a member diagnosed with PTSD were gathered. The study participants' opinions and recommendations assisted with the development of guidelines.

The data collection process for open-ended questions also included the following aspects, which were highlighted by Blaxter, Hughes and Tight (2000:164) and Chaponda (2011:58), and also deemed by the researcher as crucial in survey studies:

**4.7.6 Field notes and memos**

Field notes should be recorded for participant behavior, expressions and lack thereof (Chaponda 2011:58). In recording and reflecting upon progress, the researcher kept notes of the collected data. Though a questionnaire-led interview and voice recorder were used as data collection tools, the researcher saw it necessary to keep record of a research diary that consisted of some of the non-verbal communication that the study participants displayed. This kind of information was useful in validating findings of the study.

Lester (2005:33) stated that observational notes are objective descriptions of the events and conversations. Information such as time, place, activity and dialogue are recorded as completely as possible. Observational notes are of value in relieving the researcher of the burden of having to recall all aspects relating to the actual data collection process (Lester 2005:33). In this study, both personal and observational notes were kept. In addition, the researcher's feelings, progress, experiences of the data collection process and the research environment, such as varying family settings, which assisted with

further research processes, were recorded. This observational and experiential data, thus, served as vital referencing source.

#### **4.7.7 Literature control**

According to Chaponda (2011:58), a literature control is done with the aim of interpreting and synthesizing research done in the same field. A control of literature for this study was done in order to compare studies conducted before and to compare their findings. Vast similarities and differences were found, as well as the overall contribution of the prior studies to synthesizing the current study.

#### **4.7.8 Guiding questions**

In this study, the data collection's in-depth interviews comprised of open-ended guidance questions. This helped the researcher in guiding the interview sessions and keeping focused. Various facilitative communication skills such as paraphrasing, probing, clarifying and summarising were employed to enable full description of experiences regarding the effects of PTSD in participants' lives. Both verbal and non-verbal communication skills were employed, with much focus on non-verbal cues. Paraphrasing assisted the researcher in ensuring that the correct meaning of what the participant said was captured.

#### **4.7.9 Ensuring trustworthiness**

The aim of trustworthiness in qualitative inquiry is to support the argument that the study's findings are "worth paying attention to" (Babbie & Mouton 2003:276). According to Guba (1981:80), "The requirement for good science is justification". Trustworthiness is said to exist "where the findings of a qualitative study represent reality" (Lester 2005:41). Guba's model (1981:75), presents four aspects relevant for the establishment of trustworthiness, vital in qualitative research, namely: Credibility, transferability, dependability and conformability.

##### *Credibility*

It is an evaluation of whether or not the research findings represent a "credible" conceptual interpretation of the data drawn from the participants' original data, the compatibility between the constructed realities in the minds of respondents and those attributed to them (Babbie et al 2003:277). Credibility is closely linked to internal (face) validity of a study, which ensures that the study measures or tests what it is actually

intended (Shanton 2004:64). It deals with the question, “how congruent are the findings with reality?” Ensuring credibility is one of the most important factors in establishing trustworthiness. In addressing credibility, the researcher actually attempts to demonstrate that a true picture of the phenomenon under scrutiny is being presented (Shanton 2004:63).

Adoption of well-established qualitative research methods in general and in information science in particular is crucial in ensuring credibility. It is also vital to incorporate “correct operational measures” for the concepts being studied, thus specific procedures that are employed, such as the line of questioning pursued in data collection sessions and the methods of data analysis, should be derived from those that have been successfully utilized in previous comparable studies (Lincoln et al 1985:206 and Babbie & Mouton 2003:278) .

The credibility of this study was enhanced through prolonged involvement with study participants, reflexivity and clarification of research bias. The data was obtained from the participants themselves who were clearly identified and whose thoughts, feelings and experiences accurately described. In-depth phenomenological interviews assisted in establishing and maintaining rapport and trust relationship between the researcher and study participants. According to Lester (2005:42), the latter is essential in establishing the confidence in the truth of the study findings, thus researchers should “tell the story of the participants”. In this study, SAPS workers diagnosed with PTSD and their immediate family members were interviewed. In further addressing the aspect of credibility, the researcher employed previously utilized methods of data collection. The questions included in the data collection questionnaire were in line with the concepts studied, which were PTSD, trauma, the effects of PTSD on relations and coping. The questions were designed in a manner that allowed study participants to describe and explain in detail different aspects related to PTSD.

The other important aspect in qualitative research, as highlighted by Shanton (2004:65), and Lincoln et al (1985:301), is the *development of an early familiarity with the culture of participating organisations before first data collection processes take place*. Having a pro-longed engagement with study participants in order to gain adequate understanding of the organisation to collect data from, and to establish a relationship with of trust between the researcher and participants is crucial (Lester 2005:42). With this study, the researcher was able to establish a relationship easily as the study was conducted in the

researcher's former work environment. The researcher was familiar with the organisation's culture, gate keepers and study participants, most of whom formed part of the researcher's clientele as the EHW practitioner within the SAPS.

#### *Reflexibility (Field journal)*

The reality is that researchers practically become part of the research process and not just observers (Krefting 1991:218). The author described reflexivity as the influence that the researcher's own background, perceptions and interests may have on the study. Lester (2005:43) pointed that qualitative researchers may claim neutrality in their fieldwork, however, inherent in the feminist point of view; researchers do bring in their own perceptions, values and thoughts to the interviews. The author further stated that the researcher's background will dictate the way in which the study is organized and analysed. For this study, it was crucial that the researcher reflect on her experiences in counseling with the study participants, and on her own experiences of the effects of trauma in her life and ensured throughout the research process, especially during the interviews and data analysis focused only on what the participants shared about their own experiences. The researcher also addressed this aspect by implementing one of the strategies used to enhance reflexivity, which is maintaining a field journal, in which detailed field notes are recorded throughout the research process.

*Clarifying researcher's bias* is also crucial in ensuring that the study is credible. The researcher had interacted with most of study participants as clients and had her own experiences and perceptions regarding trauma and PTSD. The researcher also had her personal experiences of trauma, how it affected her and how she coped with it and had gathered information before the research project was thought of from various counseling sessions with SAPS workers and their immediate families. In order to ensure that her own bias did not affect the study outcomes, it was essential that the researcher present clarification of her own views and experience.

*The credibility of the researcher, e. g. background, qualifications and experience* is especially important in qualitative research as the researcher is the person who is the major instrument of data collection and analysis. Trust in the researcher is of equal importance to the adequacy of the procedures themselves. In this study, the researcher used previous experience in research and background during the research process Shanton (2004:68). A greater level of trust also existed between the researcher and participants. The researcher was well known to almost all SAPS and family members

who took part in this study due to the nature of work the researcher rendered in the SAPS organization as an EHW practitioner. This, the researcher had interacted with the participants before, as part of her work within the SAPS and this led to minimal and manageable challenges in terms of the research process, specifically with regard to data collection.

*Random sampling* is regarded as the most efficient form of selecting study sample in most literature on qualitative studies. With this study, the researcher employed purposeful sampling since the study required a focus on a specific group of subjects within the organisation, who were the SAPS workers that have been diagnosed with PTSD. The study participants were thus what Shanton (2004:65) referred to as a “selected society”.

*Triangulation* involves the use of different methods, such as observation, focus groups and individual interviews. These methods are regarded as the major data collection strategies for much of qualitative research (Shanton 2004:65; Babbie et al 2003:275). The use of different methods of data collection at the same time assists in compensating for individual use of method. Supporting data, such as statistics from documents or the organisation being studied can also be used. This assists in providing background information, explaining and indicating attitudes and behaviours or patterns of specific aspects under scrutiny, and in verifying particular details that were provided by study participants (Shanton 2004:65). In this study, the researcher used a pre-scheduled researcher-administered questionnaire to gather data from participants. Supporting data in terms of PTSD statistics was also requested and obtained from manually recorded registers and the SAPS’ electronic data base.

An element of observation was also used whereby non-verbal communication was noted and recorded during the interview sessions. The observation part of data collection gave extended information regarding some of the crucial aspects and reactions portrayed and displayed by study participants, which were not verbalised. In order to complement information collected through interviews, authority for access to data on national statistics for employees diagnosed with PTSD, the ones who have been medically boarded due to PTSD and those who have received compensation was obtained from the SAPS Head Office. The statistical information received was for the period of 2005 to 2012.

There are *tactics used by researchers to help ensure honesty* in study participants. They include giving each study participant ample opportunity to agree or give consent or disagree to participate in the study. This ensures that those partaking are genuinely willing to take part and are prepared to offer data freely (Shanton 2004:66). The researcher addressed the issue of ensuring honesty in study subjects by giving enough time to read the consent form and answered all clarity seeking questions posed in this regard. The consent form comprised of relevant information which assisted in establishing rapport and made the participants feel less anxious and at ease to share the information.

*Iterative questioning* by the researcher to elicit more detailed data on aspects previously raised by the participant is also crucial, as it enables the researcher to uncover any deliberated lies. Probing and rephrasing are ideal ways of addressing this aspect in qualitative research. The researcher ensured trustworthiness by paraphrasing and probing respondents in order to clarify specific aspects with respondents.

The issue of *peer scrutiny of the research project* implies that the researcher gave the research project to colleagues and peers in academics in order to gather comments and feedback on the procedures employed. Feedback at presentations during conferences and workshops are also good sources of obtaining information on how other researchers view the project. Peer review involves the researcher making efforts to discuss the research process and findings with impartial colleagues who have experience in qualitative research methods (Babbie et al 2003:277). The researcher asked two colleagues who had experience in qualitative research; one of them is a senior lecturer at a local tertiary institution, in Mahikeng, who gave process feedback regarding the contents of the study. Such feedback was essential in enabling the researcher to develop study content; consider using different approaches or procedures or to develop a greater explanation of the research design and strengthen arguments based on the comments and feedback received. This study was again scrutinised by two officially appointed academics who were the researcher's internal and external promoters. Feedback received from the academics allowed the researcher to use different, relevant approaches to argue certain points in the study and to present information using specific and acceptable processes.

The researcher's *reflective commentary* involves recording initial impressions of each data collection session, the patterns appearing to emerge in the data collected and the



theories generated (Guba and Lancolin 1985:144). Reflective commentary plays a role in what Guba et al (1985:232) termed “progressive subjectivity” or the monitoring of the researcher’s own developing constructions in establishing credibility. Detailed information regarding the researcher’s progressive commentary is discussed in chapter 6, (discussion of findings).

The studied concept of PTSD is sensitive in nature and was experienced as such by the researcher. The researcher observed almost similar patterns of reactions during varying interview sessions as the participants relived the traumatic experiences.

*Transferability* is closely linked to applicability of the study. It also refers to external validity, which is the extent to which study results can be applied in similar contexts on different participants (Chaponda 2011:59, Babbie et al 2003:277 and Shanton 2004:69). This included ensuring that the study was dependable and consistent. Through this, the researcher ensured that if the same study is conducted again, it would yield the same results. In this study, the latter was achieved by using truthful constructs to ensure a good fit between the social reality that is being measured through research, with the constructs that are used to understand it, for example, that the construct of PTSD fitted well into police officer’s daily exposure to trauma and the need for effective management of PTSD.

This was ensured by interviewing all participants in the most applicable settings as possible, thus linking the setting with the phenomenon under study, which was the SAPS workplace. Family members were interviewed at home, a place where they mostly experience the effects of PTSD from their father/ spouse/ parent. Furthermore, accuracy was ensured as far as possible by voice recording the interviews for detailed transcribing and provided a full description of the participants’ responses in terms of the effects of PTSD on their relations.

*Dependability* of the study was ensured by maintaining consistency, which is the extent to which the study findings are consistent if the interviews or the research process is replicated with similar participants, in similar contexts. The researcher maintained consistency by providing a full account of the research methodology and by ensuring that a standardised procedure is followed with all interviews, this was reached by not deviating from the questionnaire items with regard to all study participants. Both soft and hard copies of research interview questionnaires, raw data and reference documents used for literature review were kept safe by the researcher for clarification.

*Conformability* is closely linked to the researcher's concern to objectivity and neutrality, which limits one's characteristics, preferences or prejudices to biased study results (Chaponda 2011:60 and Shanton 2004:72). This is the extent to which the study findings are the researcher's own work. With this study, conformability was ensured by capturing the information as it was exactly given by the participants. The researcher also avoided at all times to "add a tail" or misinterpret the participants and where the researcher was unclear about a particular response, a request was made for the participant to elaborate more in order to capture their true opinion, feelings and experiences, and not those of the researcher.

A voice recording device was used as part of data collection; this assisted the researcher later on with the process of transcribing as there was more data captured on the voice recorder than that captured by hand with the questionnaire completion. Some of the study participants actually shared more information at the same time, which in some instances was difficult for the researcher to capture by writing. As a result, the information from the voice recorder provided more information. Another important aspect was being aware at all time of the sensitivity of the PTSD phenomena. The researcher thus ensured the establishment of rapport and was on the alert for any reactions which could have arisen from the in-depth interviews.

#### **4.7.10 Open-ended questions survey**

An unstructured questionnaire, one for each group of study participants with open-ended questions was used. The participants' responses were recorded using a digital voice recorder in order to minimize chances of misinterpreting data and to avoid missing valuable information captured by hand. The interview data was saved on USB flash drive and desktop and on the recorder, to allow for security and backup purposes, in case the flash disk got lost or misplaced, or any other loss or damage to the crucial data which might happen.

#### **4.7.11 Obtaining written approval to conduct the study**

Approval was obtained from relevant authorities within the SAPS organization, at station, cluster, provincial and national levels to access information from staff records and to acquire statistical and comprehensive reports on the onsite occupational health programmes from the national EHW, the EHW North-west Provincial and from the EHW Mahikeng area offices.

#### **4.7.12 Communication with study participants**

Communication with study participants involved the researcher's clients as former SAPS EHW Practitioner, who had previously been referred by specialist psychiatrists for work-related intervention, family assistance and support. Initial contact was done with the SAPS workers, who later on gave consent for the researcher to engage their immediate family members. Some of the workers did not consent to their families' participation in the study, on personal grounds.

#### **4.7.13 Communication with other data sources**

Formal liaison, in the form of letters addressed to the SAPS leave sections of all police stations and police units falling under Mahikeng Cluster, was done. The letters outlined the purpose of the study, confidentiality, and request for data on SAPS workers who had been diagnosed with PTSD. The Leave Section personnel were aware of the workers' health condition as it is indicated on the medical certificates submitted and captured on the leave management system. The data was further requested in the form of face to face, telephonic, email and letters requesting information from other psychiatrists, known to the researcher in and around Mahikeng and with Mahikeng Cluster EHW professionals.

#### **4.7.14 Conducting in-depth interviews**

Both face to face and telephonic interviews were conducted in this study. Telephone interviews had to be conducted with few of the family members, namely parents and SAPS worker's children as most of them were not staying with their parents and are working outside the Mahikeng area. Almost all study participants were cooperative and responsive to the researcher; this made the data collection process manageable.

#### **4.7.15 Use of a voice recording device**

A voice recording device was used as part of data collection. This assisted the researcher later on with the process of transcription as there was more data captured on the voice recorder than was captured by hand during the questionnaire completion. Some of the study participants would actually share more information at the same time, which in some instances was difficult for the researcher to capture in writing. As a result, data from the voice recorder provided more clarity. Another important aspect related to the need for a constant awareness of the sensitivity of the PTSD phenomena.

Thus, the researcher ensured the establishment of a rapport and was on the alert for any reactions which could arise from the in-depth interviews.

#### **4.7.16 Data transcription**

Data transcription from the open-ended questions was done by the researcher and an independent transcriber immediately after all interviews were conducted. The other data collected mainly in Setswana required translation from Setswana to English by a qualified translator. The translation was facilitated by a Setswana teacher obtained from the onsite tertiary institution. Translation was followed by data analysis.

### **4.8 DATA ANALYSIS**

The services of a professional statistician were sought to conduct the analysis of data from closed ended questions. A Statistical Package for the Social Sciences (SPSS 20.0.1) version was used to analyse data on the prevalence and effect of PTSD among the SAPS workers. Open-ended questionnaire items were analysed by identifying common themes from the participants' responses to assist in the development of practical guidelines to manage PTSD within the SAPS organisation.

Data was sorted out in two folders. Data from closed questions was summarised and presented in tabular and graphical formats. Measures of central tendency: mean, median and mode and dispersion: standard deviation, range etc. were calculated for other demographic data, including participants' age. An analysis of data from open-ended questions was conducted using the excel programme to record and group together data into common themes. The themes were developed on the basis that the responses provided by different respondents on each questionnaire item were directly the same. Furthermore, some of the responses from various respondents carried exactly the same meaning. These were grouped together as themes.

Both the statistician and language translator gave consent to keep the information confidential. The statistician is a researcher and statistical studies lecturer. The translator and statistician's academic training and experience in research were used as a basis for including their contribution and assistance with regard to the data analysis process.

Data was manually cleaned before running the statistical analysis. Analysed data was based on a total of 19 SAPS workers and 23 family members including parents,

spouses and dependents of workers who took part in the study. The quantitative survey analysis yielded results on the prevalence of PTSD in the Mahikeng area and an indication of the number of the SAPS families affected by the effects of PTSD. Authorized statistical data on all SAPS workers diagnosed with PTSD within the North west province and in the Mahikeng area was obtained from the SAPS Head Office, Employee Life Cycle Management: Sub Section: Occupational Incidents office and from the Section Head: Medical Administration. This was plain numerical and anonymous data with no indication of the workers' names. The data was used to compliment and validate the main findings of the study.

#### **4.9 ETHICAL CONSIDERATION**

Ethical considerations included, ensuring confidentiality; getting clearance from the University of South Africa (UNISA), permission by the SAPS organisation at Mahikeng cluster, provincial and national level and participant informed consent; avoiding participant deceit and ensuring participant anonymity and privacy.

##### **4.9.1 Participant anonymity and privacy**

To maintain anonymity and privacy of the research participants, the researcher only used coding for each interview questionnaire and recorded information. The study's printed results did not have any data that identified any of the participants. Some of the study participants did not feel comfortable with the researcher interviewing their family members. The researcher respected their feelings and decisions in this regard.

##### **4.9.2 Confidentiality**

Given the sensitivity of the issue of trauma and PTSD, the researcher prioritised the aspect of confidentiality. All information related to the study participants was treated with the strictest confidentiality and respect. This information was kept in a lockable cabinet, where only the researcher had access to the keys. Copies of questionnaires and recorded information were kept in a locked drawer until the research was finalised and accepted by examiners. After a period of three years, all the information will be destroyed by the researcher to maintain participant anonymity and privacy. No participant identifying information was recorded on the questionnaires.

#### **4.9.3 Ethical clearance**

The study proposal was reviewed by the Health Studies Research and Ethics Clearance Committee (HSREC) at UNISA and an ethical clearance approval to conduct the study using human participants and study records was provided (Annexure C).

#### **4.9.4 Permission by the SAPS organisation**

The aspect of permission to conduct the study within the SAPS organisation was also crucial. Written consent was requested from the Mahikeng Police Station Commander and the Cluster Commander who forwarded the request to the North West Provincial Commissioner who then liaised with the National Head: Strategic Management and granted permission (Annexure A), The SAPS National Office Head: General Research and Curriculum Development (Human Resource Development) (Annexure B).

#### **4.9.5 Informed consent**

Obtaining written consent from the study participants to partake in the study was of utmost importance (Annexure D). Participants were allowed ample time to read, understand and ask questions (clarity-seeking) related to the consent form before granting personal consent to partake in the study. The consent form highlighted detailed information on what the study was all about, confidentiality, anonymity/privacy and the duration of the interview session. The researcher highlighted to the study participants, their right, underscored on the consent form, to discontinue with the study if they so wished. The fact that the study will have no influence on their regular work as police officers and on relationship as family members was also mentioned. An estimated duration of the interview was also highlighted in the consent form. Written Consent for children to partake in the study was obtained from parents.

#### **4.9.6 Avoiding harm**

In order to avoid harm to study participants; a professional support network was established by the researcher. This included arranging health, spiritual and mental professionals to be on standby for immediate reach in case the need arose for counseling or intervention. The availability of social workers, a specialist psychiatrist, psychologist and chaplain were arranged in this regard.

#### **4.9.7 Avoiding participant deceit**

The issue of study participant deceit was avoided at all times during and after completion of the study. This was achieved by reporting back to study participants, confidentially giving them information on the progress and eventually on the general study findings.

#### **4.9.8 Ethical considerations related to data collection**

The researcher normally received referrals from external sources such as psychologists and specialist psychiatrists in and around Mahikeng, for clients diagnosed with PTSD for the researcher's office intervention and support to the specific workers. These external professionals were contacted and liaised with telephonically and face to face consultations held, whereby an extensive outline of the study aim and objectives was done.

All of the referrals used in this study were received from the specialist psychiatrists due to the fact that local General Practitioner (GPs) (Medical doctors) and psychologists usually refer clients for psychiatric diagnosis of PTSD and its treatment. Thus, according to the Circular Instruction 172-PTSD (2002:1), psychologists and GP's are ethically not allowed to make PTSD diagnosis, only a specialist psychiatrist can.

Consent forms were issued for communication with clients working in and around Mahikeng diagnosed with PTSD. This specific arrangement was made for those clients who were not yet referred to the researcher, (not yet on the researcher's data base), and to avoid omissions in terms of the study population. A consented name list of all SAPS workers diagnosed with PTSD was obtained from onsite specialist psychiatrist.

Internally, SAPS EHW professionals were also consulted. The same procedure followed with the external resources was used in this instance. Caution was exercised by not allowing the EHW personnel who were not comfortable to engage their clients to partake in the study as their feelings and decisions were respected.

#### **4.10 CONCLUSION**

This chapter discussed all processes such as research design, study sample and sampling techniques, study data collection tool development, pilot study, and how the actual data collection process unfolded and how data was analysed, during the study. Ethical considerations for the study were also explained to ensure high ethical

standards. This chapter also described issues pertaining to the internal and external validity of the study. The next chapter, chapter 5, analyses and presents the descriptions of the research findings.



## CHAPTER 5

### DATA ANALYSIS, PRESENTATION AND DESCRIPTION OF RESEARCH FINDINGS

#### 5.1 INTRODUCTION

This chapter presents the research findings of data obtained from two groups of participants, namely the SAPS workers and their immediate family members, based in Mahikeng, North West Province, South Africa. Data obtained from both groups of participants is presented in two sections; the first section presents findings from the SAPS workers and the second findings from the family members' data. The participants' demographic data is also presented. The chapter further presents data on traumatic incidents that led to PTSD and health and social effects of PTSD. In addition, the effect of living with a family member diagnosed with PTSD, as reported by family members, is presented. Coping mechanisms reportedly used by participants to deal with PTSD are also presented. The findings also present the prevalence of PTSD and the nature of workplace interventions available at the research site.

#### 5.2 SECTION A: PARTICIPANTS' PRESENTATION OF FINDINGS

**Table 5.1 Participants' demographic characteristics (N=19)**

Category	Frequency	Percentage
<b>Age</b>		
26-29 years	3	15.8
30-39 years	2	10.5
40-49 years	11	57.9
50-59 years	3	15.8
<b>Gender</b>		
Female	5	26.3
Male	14	73.7
<b>Home language</b>		
Afrikaans	1	5.2
Xhosa	1	5.2
Sesotho	1	5.2
Setswana	14	74.0
Tsonga	1	5.2
Sepedi	1	5.2

Category	Frequency	Percentage
<b>Ethnicity</b>		
White	1	5.2
African	18	94.8
<b>Educational qualifications</b>		
Matric	7	37.8
Standard 9	3	15.0
1-2 year Diploma	6	32.2
3 year Degree	3	15.0
<b>Rank distribution</b>		
Constable	5	26.3
Sergeant	3	15.7
Warrant Officer	7	37.2
Lieutenant	1	5.2
Major	1	5.2
Lieutenant Colonel	1	5.2
Colonel	1	5.2
<b>Years of service</b>		
0-10 years	5	26.3
11-20 years	4	21.1
21-36 years	10	52.6
<b>Marital statuses</b>		
Married	12	63.3
Single	6	31.5
Widowed	1	5.2
<b>Religion</b>		
Christian	19	100.0

A total of 19 workers out of 26 workers diagnosed with PTSD at the study site were accessible to the researcher and gave an informed consent to take part in the study , thus giving a response rate of 73%.

Their demographic characteristics are illustrated in table 5.1. The results showed that 11 (57.9%) participants, were between 40-49 years, followed by those between 26-29 years 3 (15.8%) and 50-59 years 3 (15.8%). Those between 30-39 years were 2 (10.5%). Most participants 14 (73.7%) were females compared to males 5 (26.3%) as presented in figure 5.2. With regards to home language, more than two-thirds, 14 (74.0%) of the participants' home language was Setswana, followed by North Sotho, South Sotho, Afrikaans, Xhosa and Tsonga, which constituted equal proportions of 1(1.5%).

The analysis, as indicated in table 5.1 further showed that almost all of the participants 18 (94.8%) were predominantly African, while the minority, 1 (5.2%) belonged to the white ethnic group. Regarding the highest level of education, 7 (37.8%) had Matriculated whilst 3 (15.0%) had a below matric (standard 9) qualification. The analysis further indicated that 6 (32.3%) had diploma qualifications while 3 (15.0%) had three years degree qualifications as shown in table 5.1.

Regarding the participants rank distribution, 7 (37.2%) were Warrant Officers. Those at the rank of Constable constituted 5 (26.3%), followed by Sergeants 3 (15.7%). Participants at the ranks of Colonel, Lieutenant Colonel, Major and Lieutenant only formed 1 (5.2%) of the participants respectively. Ten (52.6%) participants had more than 20 years of working experience in the police organisation as compared to those falling within the range of 01-10 years who constituted 5 (26.3%). Four (21.1%) had between 11-20 years' work in the police organisation as shown in table 5.1. The analysis further showed that 12 (63.3%) of participants were married, compared to 6 (31.5%) who were single. Only 1 (5.2%) participant reported that she was a widow. With regards to religion, all participants (100%) were Christians.

### **5.3 PREVALENCE OF PTSD AMONG THE SAPS WORKERS**

#### **5.3.1 National PTSD prevalence**

From the records reviewed, a total of 2 763 South African police workers were diagnosed with PTSD from a total population of 160 000 active police workers during the year 2005-2012. Therefore the national PTSD prevalence rate was calculated using the number of workers reported to have been diagnosed with PTSD and the total number of active police workers over a 7 year cycle, thus from 2005 to 2012. The analysis indicated the national PTSD prevalence rate of 1.72%, calculated as follows:

$$\frac{2763 \times 100}{160000} = 1.72\%$$

#### **5.3.2 Local PTSD prevalence**

Findings from a review of records from the office of the Mahikeng cluster commander, showed that the total number of SAPS workers in the Mahikeng area was 2 500 during the period when the study was conducted in 2013. Out of the 2 500 active police work

force, 19 workers diagnosed with PTSD consented to take part in this study. The analysis showed that the life-time prevalence rate of PTSD among the SAPS workers in the Mahikeng area was 0.76%. The prevalence rate was calculated as shown below:

The total number of PTSD cases x100

The population size

Thus: **19 x100**

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$$2\ 500 = 0.76\%$$

#### 5.4 NATURE OF TRAUMATIC INCIDENTS LEADING TO PTSD

Findings on the nature of traumatic incidents that caused PTSD among participants are shown in Table 5.2. Records reviewed showed that 14 (73.7%) of the participants' traumatic incidents were work-related compared to 5 (26.3%) that were not work-related.

**Table 5.2 Nature of traumatic incidents leading to PTSD (N=19)**

Nature of traumatic incident	Frequency	Percentage
Work-related	14	73.7
Non-work-related	5	26.3
<b>Total</b>	<b>19</b>	<b>100.0</b>

#### 5.5 TYPES OF WORK-RELATED TRAUMATIC INCIDENTS LEADING TO PTSD

Table 5.3 shows that participants exposed to shooting, rape and gruesome murder scenes as well as colleague and community members' suicides constituted equal proportions of 5 (34.1%). Three (18.6%) participants indicated that they had been exposed to gruesome motor vehicles and plane crashes. Only 1 (13.2%) reported prisoner escapes as a work-related traumatic incident which served as a stressor leading to the possible development of PTSD as shown in table 5.3. In addition, the reviewed records showed that some participants' PTSD diagnosis was due to exposure related to attending scenes of gruesome motor vehicle and plane crush accidents, gruesome murder scenes and detainee escape incidents.

**Table 5.3 Types of work-related traumatic incidents leading to PTSD (N=14)**

Type of work-related traumatic incident	Frequency	Percentage
Prisoner escapes	1	13.2
Gruesome motor vehicle accidents and plane crashes	3	18.6
Community member and colleague suicides	5	34.1
Shooting, rape and murder scenes	5	34.1
<b>Total</b>	<b>14</b>	<b>100.0</b>

## **5.6 PARTICIPANTS' EXPERIENCES OF NON-WORK-RELATED TRAUMATIC INCIDENTS LEADING TO PTSD**

Out of the 5 participants who reported exposure to non-work-related traumatic incidents that led to PTSD, equal proportions of 2 (42.8%) were due to marital problems and the loss of loved ones as shown in table 5.4. Only 1 (14.4%) participant developed PTSD as a result of being a victim of a motor vehicle accident.

**Table 5.4 Types of non-work-related traumatic incidents leading to PTSD (N=5)**

Type of non-work-related traumatic incident	Frequency	Percentage
Marital and relationship problems	2	42.8
Loss of loved ones	2	42.8
Motor vehicle accidents	1	14.4
<b>Total</b>	<b>5</b>	<b>100.0</b>

## **5.7 EFFECTS OF PTSD ON PARTICIPANTS**

### **5.7.1 Health effects of PTSD on participants**

Living with PTSD was reported by participants as having precipitated a number of physical and psychological health conditions among them. Table 5.5 shows that 6 (32.2%) of the participants reported experiencing insomnia. Those with constant irritability, feelings of distrust and anger constituted 3 (15.8%) of the participants.

Furthermore, proportions of 2 (10.4%) are noted with participants who reported relying on psychiatric medication in order to be fully functional in their daily duties. Thus, without taking medication, the 2 participants would be overwhelmed by reactions and could not perform to their best ability. Two (10.4%) of the participants reported experiencing hypertension subsequent to PTSD diagnosis. Two (10.4%) of the participants reported experiencing blood circulation problems due to the stress caused

by PTSD development. The ones who experienced knee and back pains constituted 2 (10.4%). Two (10.4%) of the participants reported experiencing nervous breakdowns due to developing PTSD.

**Table 5.5 Distribution of the health effects of PTSD on participants (N=19)**

Health effect	Frequency	Percentage
Insomnia	6	32.2
Irritability, distrust and anger	3	15.8
Reliance on psychiatric medication	2	10.4
Hypertension	2	10.4
Blood circulation problems	2	10.4
Back pains	2	10.4
Nervous breakdown	2	10.4
<b>Total</b>	<b>19</b>	<b>100.0</b>

### 5.7.2 Social effects of PTSD on participants

With regards to social effects of PTSD, 12 (63.3%) of the participants reported that they withdrew from socializing with their friends, while 5 (26.3%) avoided participating in social networks and social events. Only 2 (10.4%) reported the lack of support from their friends and co-workers, as shown in table 5.6.

**Table 5.6 Distribution of the social effects of PTSD on participants (N=19)**

Social effect	Frequency	Percentage
Withdrawal from friends	12	63.3
Avoidance of social networks and events	5	26.3
Perceived lack of support from friends and colleagues	2	10.4
<b>Total</b>	<b>19</b>	<b>100.0</b>

## 5.8 PARTICIPANTS' COPING MECHANISMS TO DEAL WITH PTSD

As illustrated in table 5.7, 6 (34.5%) of the participants reported that they relied on support from their family members and friends for care and sustenance in coping with PTSD. Four (17.5%) of them relied on the guidelines and life skills learnt and obtained from professional counselling sessions they had attended at the SAPS EHW offices and from sessions held with mental health professionals external to the SAPS organisation.

Furthermore, equivalent quantities of 2 (10.7%) reported having coped through by focusing on and practicing their interests such as reading books and magazines, taking part in sports, designing wood art, shopping and watching movies. Two (10.7%) participants reported that they had coped by avoiding their friends and memories and feelings related to the trauma, while 2 (10.7%) of them reported that they felt that they were chosen by God to do police work, as a result, they were motivated to carry on even when it was difficult to cope with the job demands. Two (10.7%) participants reported that they coped by praying together with their relatives. Only 1 (5.2%) participant mentioned indulging in alcohol and smoking as a way of dealing with PTSD.

**Table 5.7 Participants coping mechanisms to deal with PTSD (N=19)**

<b>Coping mechanism</b>	<b>Frequency</b>	<b>Percentage</b>
Use of support from family and friends	6	34.5
Exercising hobbies	2	10.7
Avoiding friends and avoiding traumatic thoughts and emotions	2	10.7
Attending church and praying as a family	2	10.7
Use of professional counselling services	4	17.5
Use of alcohol and smoking	1	5.2
Having a sense of duty: being strong and feeling mandated to do policing work	2	10.7
<b>Total</b>	<b>19</b>	<b>100.0</b>

## **5.9 AVAILABLE ONSITE OCCUPATIONAL HEALTH INTERVENTIONS FOR THE MANAGEMENT OF WORKERS WITH PTSD**

As part of the research project, the researcher assessed the available on-site procedures and occupational health programmes implemented to assist workers with PTSD management at the study site. The following findings, based on records reviewed on onsite interventions seeking to manage workers with PTSD, were identified: (1) various occupational health and wellness programmes were in place to support the management of workers with PTSD and (2) The programmes are divided into primary, secondary and tertiary levels of prevention, and were employed during the time of conducting the study:

## **5.9.1 Primary prevention**

### **5.9.1.1 *Induction training***

The reviewed records indicated that comprehensive induction training is offered to all new workers recruited within the SAPS organisation. The training entails physical and content presentation about the SAPS organisation's policies, processes and procedures with the aim of physically and psychologically preparing the new appointees with the physical and mental strength required in the policing profession. The training also provided background information about the organisation and what their work would entail.

### **5.9.1.2 *Life skills training***

Some of the programmes offered as part of police workers' empowerment include Life skills programmes seeking to empower workers with essential skills to assist them buffer against the stress and trauma encountered in police work, and to be pro-active in lessening the risk of possible PTSD development among the workers. The programmes include presentations on financial, stress, conflict, trauma, self and people management skills and suicide prevention.

### **5.9.1.3 *Marketing of EHW services and awareness information about PTSD***

The SAPS EHW professionals provide promotional and educational information sessions to the workers, specifically highlighting support services offered by the EHW Unit. The information regarding trauma and PTSD and symptoms leading to the possible development of PTSD are provided, given the constantly traumatising nature of police work. Supplementary educational information that was provided includes awareness on reactions toward trauma and its effects as well as trauma and PTSD management strategies. Furthermore, information on the advantages and disadvantages of utilising and not utilising the trauma debriefing services, intended to prevent the development of PTSD are offered to the workers.

### **5.9.1.4 *The SAPS EHW wellness days***

This programme is aimed at promoting individual physical wellness and fitness. The programme is conducted in conjunction with the POLMED during which workers are educated on healthy living and undergo various vital health screening assessments with the aim of encouraging them to pro-active, detect illnesses at an early stage and being



effective in managing diseases and chronic health conditions. Various sport codes, and indigenous and recreational games form part of the wellness days to stimulate active living and physical wellness. Workers diagnosed with PTSD also form part of the wellness days where they are encouraged to adopt and maintaining healthy lifestyles including observing balanced diets and regular exercises.

## **5.9.2 Secondary prevention**

### **5.9.2.1 *Initial debriefing/defusing***

Findings from the reviewed records showed that an initial debriefing program, also known as defusing is offered to traumatised workers by commanders who have been trained as initial debriefers (defusers). Initial debriefing is offered immediately after exposure to trauma. This occurs usually, one to two hours after attending to the traumatic scene, with the intention of managing the traumatic reactions at an early stage and preventing the reactions from developing into more intense responses which may later on place workers at risk of developing PTSD.

The aim of initial debriefing is to provide immediate support and assistance after exposure to trauma. The researcher also noted that the initial debriefing aimed to achieve the following:

- To enable ventilation of initial thoughts and feelings regarding the traumatic incident.
- Stabilise the workers so that they can return home without unusual stress.

After conducting this type of a session, the defuser refers the traumatised workers to the SAPS EHW professionals for what is termed formal debriefing.

### **5.9.2.2 *Formal debriefing***

A review of the current systems used in the SAPS organisation showed that formal trauma debriefing and PTSD development prevention sessions are offered to workers who were involved in traumatic incidents. This is offered 72 hours after a traumatic incident. Formal debriefing is a detailed session during which traumatised workers are given an opportunity to explore their experiences, thoughts and emotions attached to the traumatic incident. The principle of confidentiality is emphasised during the session. The sessions are educational in nature, focusing more on equipping traumatised

workers with effective coping mechanisms. The sessions are provided by social workers, chaplains, and psychometrists who are also trained formal trauma debriefers. Formal trauma debriefing also aims to achieve the following:

- reduce the risk of PTSD occurring
- provide immediate counselling and support after a traumatic incident
- lessen the psychological impact of a traumatic event
- facilitate early identification of traumatised workers who may require professional mental health
- help workers to make sense of traumatic incidents and educating them on the normalcy and predictability of the reaction
- help traumatised workers realise that they are still normal even after experiencing the reactions after trauma
- help workers regain control of their lives, responsibilities and policing tasks
- examine future needs of an individual, family, peer and social group
- raise awareness at personal, group and organisational level

#### ***5.9.2.3 Psycho-social, spiritual counseling, hospital and home visit services***

Workers diagnosed with PTSD and their immediate family members are also offered counseling to assist them on how to cope with the experiences psycho-social and spiritual challenges. The SAPS EHW professionals offer counseling sessions when requested by the worker or when a need to render such services is identified. Other intervention, counseling, support and treatment services by external health and wellness professionals, including psychologists, psychiatrists and medical doctors, are also employed following worker referral by the SAPS EHW office or as a result of self-referrals by the workers. Workers diagnosed with PTSD are also visited by the EHW professionals during ill-health periods, thus the support visits are conducted at home and at health institutions, including mental and physical rehabilitation, psychiatric and wellness hospitals, where the worker would be admitted at.

#### ***5.9.2.4 Multiple Stressor Debriefing (MSD) programme***

The reviewed records specified that the Multiple Stressor Debriefing programme is implemented within the SAPS organisation as an on-site intervention and management programme for trauma and PTSD. The MSD programme recognises that workers are exposed to demands stemming from various spheres of their lives including personal,

family, work and social areas. This programme is offered specifically to the workers placed at units identified as “high risk units”. The units include among others, the LCRC, FCS and the Detectives units. Thus, working in these units exposes them to constant trauma than working in other units within the SAPS organisation.

The multiple stressor sessions are aimed at the following:

- Enabling workers to ventilate about a variety of stressors emanating from their daily policing work.
- Providing open opportunities for workers to talk frankly about personal or social matters negatively affecting them in a group setting.
- Creating chances for workers who find it difficult or uncomfortable to talk about personal stressors in a group setting to arrange for individual counselling and support with the relevant SAPS EHW professionals.

The multiple stressor sessions are held on a quarterly basis. The sessions are facilitated by the EHW personnel who creatively use a variety of stress management and relaxation approaches to help the workers unwind. This includes activities such as fun art work, body and mental relaxation exercises, expressing thoughts and emotions using magazine collages, group interactive exercises and interpersonal/intrapersonal as well as team building activities.

#### ***5.9.2.5 A 24 hour crisis intervention and stand-by service***

Findings from the reviewed records indicated the availability of a 24 hour service dedicated to rendering immediate support to the general SAPS workforce and to the workers diagnosed with PTSD during the time of need. Spiritual and psycho-social intervention and support is also rendered to the workers diagnosed with PTSD and their immediate family members through this programme.

#### ***5.9.2.6 The SAPS EHW National Call Centre***

A team of professionals manage the call centre located at the SAPS headquarters. This centre serves as a service point for intervention and a referral source for psycho-social and spiritual services for all provinces. The SAPS Workers and their immediate family members requiring trauma and PTSD support and management services are also referred to the EHW office through this programme.

### **5.9.3 Tertiary prevention**

#### **5.9.3.1 PTSD support group**

Further review of the implemented systems revealed that one PTSD management and support group existed in the SAPS North-West province. The support group is facilitated by a psychological service professional that, during the time of conducting the study, was the only worker based at psychological services' provincial office. The support group aimed at the following:

- Identifying PTSD reactions experienced by the workers.
- Encouraging team and group solidarity, through discussion of the physical (behavioural), emotional and psychological reactions experienced.
- A normalisation of the reactions experienced and realising that other group members also experienced the same or even worse reactions.
- Providing workers who are on PTSD medical treatment with opportunities to share experiences about the effects of medication on their work, social and family lives and offer necessary support as identified by the facilitator or reported by the worker.
- Enabling workers experiencing side-effects impacting negatively on job performance to share experiences and follow the necessary arrangements made by the facilitator with the worker's immediate commander, in terms of alternative and supportive job placement.
- Discussing and educating workers on effective coping mechanisms.
- Assessing and identifying individuals who may require referral to external health and mental professionals, including specialist psychiatrists, medical practitioners and psychologists, and making necessary follow up with them.
- Informing the workers about the need to report any PTSD symptoms which may be worrying and calling for immediate attention to management and EHW.
- Offering contact numbers, including the 24 hour provincial psychological services stand-by number, in case of further psychological assessment, intervention and support.
- Assessing the availability of family support and rendering necessary assistance and support for workers in need as observed and/or assessed or as per the worker's request.

Workers diagnosed with PTSD attend the support and management group sessions held only at the provincial psychological office. These sessions are normally held fortnightly. The specific support group encompasses workers who are based at other clusters in the vicinity and outside of the provincial offices. A review of the records indicated that only a few of the workers were taking part in the PTSD group support sessions owing to lack of transport to travel from various clusters to the provincial office and heavy work load. The record review indicated further that most of the workers diagnosed with PTSD did not seem to be willing to partake in the support group sessions, while others only attended once. The review also indicated that none of the workers diagnosed with PTSD, who are working in the Mahikeng cluster, were part of the trauma support group held at the provincial office. Furthermore, there are no trauma support group sessions that are held in the Mahikeng area. The researcher also noted that there were only two chaplains and one occupational social worker and no psychological services personnel at the study site.

#### ***5.9.1.2 The SAPS Sports programme***

Various sporting and recreational and indigenous codes including soccer, volleyball, tennis, chess, netball, table tennis, athletics, aerobics, bowling and fishing, form part of this programme which aims at encouraging active lifestyle and relaxation among the workers. Workers from different provinces and police stations also get an opportunity to network with one another at station, cluster, provincial and national levels of sport competitions. This programme also is based on the notion that actively participating in sports and recreational activities serves as a great buffer against negative stress.

#### ***5.9.1.3 The POLMED Psychiatric disease management programme***

The POLMED Psychiatric disease management programme is also offered to the workers diagnosed with PTSD as a support management and rehabilitation programme.

The POLMED psychiatry programme manages a variety of health conditions including depression, PTSD, bipolar mood disorder and substance abuse. In order to enroll on the program, workers are required to have an enrolment form obtainable from the POLMED website completed by their treating doctor and returned by post or e-mail. Once enrolled on the program, the workers receive a care plan and quarterly telephonic follow-ups inclusive of the following services:

- Provision of information and guidance to improve understanding and management of the disease.
- Assistance in getting authorisation for appropriate health care services.
- Co-ordination of medical treatment with the treating doctor.
- Answering care plan enquiries.

In the WTM, the current findings on available onsite occupational health interventions for management of workers with PTSD are concomitant with the component of promoting mastery of traumatic reactions.

## **5.10 PARTICIPANTS' OPINIONS AND RECOMMENDATIONS FOR PTSD MANAGEMENT**

The analysis in table 5.8 indicates that 5 (35.2%) of participants thought that they would be able to manage PTSD if the SAPS organisation could offer all workers diagnosed with PTSD sufficient care and support. This is what they had to say about this aspect:

"They must take care of their employees thoroughly and fully support and assist them because sometimes you can experience problems and think of something else ... like suicide."

"They must support us by visiting all of us who are affected. All services must reach all of us, not only few benefiting from the SAPS support, it is not right that way because all of us need it."

Four (17.3%) participants' views were that provision of adequate integrated family counselling and empowerment sessions was critical. This is how they substantiated this aspect:

"Workshops should be presented ... Even if I am medically boarded, they must workshop me, get me to give input ... I should not be put aside; I must still work with SAPS... My family will also be satisfied ... SAPS should still continue to attend to me and my family ... I must be invited for family advices."

Two (10.7%) of the participants wished to be released from work on medical grounds, due to PTSD. They said:

"I would also appreciate if I can be booked off medically because I am struggling ... Most of the time I am admitted and it is not nice... e.g. in a year, I work for only four months ... it is strenuous and tough ..."

"Mine is just to be released from my duties ... I feel that going on working will totally destroy me and my family will lose me if I totally lose my mental capacity ... if I am out of the service I can relax and be on the treatment ... I ask myself whether the SAPS authority want to see me being permanently impaired or die on duty ... is it only then when the SAPS realises the seriousness of the case? I feel that I can't work anymore ... I have done my part ..."

Equal proportions of 1 (5.2%) are noted in table 5.8 for participants whose views included a need for continued provision of adequate trauma debriefing and PTSD management services, a need for marketing of the SAPS EHW services, commander support and suitable placement for workers diagnosed with PTSD. The participants' views included the following:

"Commanders are not cooperative, they have to be sensitive and they need to know patients with PTSD and other illnesses, understanding of the health condition, proper consultation. They must not downgrade you or look down at you...they don't feel what is inside you, I need an opportunity to be looked at differently and be supported, do not be ignorant ... in terms of PTSD members, there must be proper communication, commanders must approach us humane. Commanders and colleagues must be more informed about PTSD ... introduce EHW programme in all police stations, most members do not know about EHW and that they can get psychologists from SAPS. They must market EHW services."

"Trauma debriefing sessions can continue to be offered ... when you have PTSD, the leave that you get is assisting ..."

The need for workers with PTSD to receive job transfers to stations nearer to their families was raised by 1 (5.2%) participant. He said:

"I think they should place people who are diagnosed with PTSD in suitable work environments which will not traumatise them again ... also please assist me in terms of an alternative placement, as recommended by the psychiatrist... that I must not do operational duties anymore ... until I have fully recovered."

One (5.2%) participant pleaded for reduced workload for workers with PTSD. This is what she understood to be the necessity of decreased work:

"Reduce my workload or give me more person power ... The thing is they cannot reduce the dockets...it is difficult for me to work during the night because I take

medication ... Allow me to work day shifts only so that I do not default my medication ... Even during special operations ... I can work during the day only."

Three (10.8%) of participants viewed the establishment of support groups, participating in various occupational sports activities and offering education to co-workers about PTSD as critical. They verbalised this by saying:

"It is important for our colleagues to know about some of the things you do when you have PTSD ... for example, when I cry at work ... Understand. They should support and understand that this person is having this kind of sickness. Start a support group in this regard ... different sport activities ... help me offload in anyway."

"Our colleagues need to understand about our health condition. People see me coming to work... they think that I am OK ... They don't bother to ask about my stress level or my well-being... instead they say bad things like "I am crazy ..."

Furthermore, offering job promotion and recognising the bravery and critical contribution made by workers diagnosed with PTSD's to the SAPS organisation was viewed by 1 (5.2%) worker as important. The worker pointed out that those workers diagnosed with work-related PTSD should be presented with certificate of bravery and a monetary appreciation for their hard work and dedication:

"... SAPS must motivate us by giving us certificate of bravery and job promotion at station and cluster level in order to encourage those who can be involved like us in serious and violent scenes ... If they don't do so, other workers will be demoralised."



**Table 5.8 Participants' opinions and recommendations for PTSD management (N=19)**

<b>Opinion</b>	<b>Frequency</b>	<b>Percentage</b>
A need for continued provision of adequate trauma debriefing and PTSD management services	1	5.2
A need for provision of adequate integrated family counselling and empowerment sessions	4	17.3
Establishment of support groups, various sport activities and educate co-workers about PTSD to discourage labelling and discrimination	3	10.8
A need for marketing of the SAPS EHW services, colleague and commander support and suitable placement for workers diagnosed with PTSD	1	5.2
Job transfers nearer to families and suitable alternative job placement of workers with PTSD	1	5.2
A need for reduced workload for workers with PTSD	1	5.2
Establishment of corporate recognition and acknowledgement programmes for workers diagnosed with work-related PTSD	1	5.2
Approval and discharge of workers with PTSD on ill-health retirement (medical boarding)	2	10.7
Offer adequate care and support through home/ hospital visits to all workers with PTSD through capacitated professionals within the SAPS organisation	5	35.2
<b>Total</b>	<b>19</b>	<b>100.0</b>

#### **5.11 SECTION B: FAMILY MEMBERS' FINDINGS – FAMILY MEMBERS' DEMOGRAPHIC CHARACTERISTICS**

A total of 23 family members participated in the study. As shown in table 5.9, 12 (52.8%) of them were children to the SAPS workers, followed by 5 (21.2%) who were their spouses. Four (17.3%) were the SAPS workers' parents. Only 2 (8.7%), were siblings of the SAPS workers who were still residing with their parents.

**Table 5.9 Distribution of family members' relationship to the SAPS workers (N=23)**

<b>Relationship</b>	<b>Frequency</b>	<b>Percentage</b>
Partner	5	21.2
Child	12	52.8
Parent	4	17.3
Sibling	2	8.7
<b>Total</b>	<b>23</b>	<b>100.0</b>

## **5.12 THE EFFECTS OF LIVING WITH A FAMILY MEMBER DIAGNOSED WITH PTSD**

### **5.12.1 The health effects of living with a family member diagnosed with PTSD**

As shown in table 5.10, living with a family member diagnosed with PTSD was reported to have brought about intense worry and trauma as well as feelings of insecurity among 9 (38.9%) of the family members due to the changing moods, development of new habits and unpredictable behaviour of their father or spouse. The following are family members' verbal reports:

"... it is traumatic ... I often get worried for her safety ... she is working far..."

"He is on and off, since he got diagnosed, he is moody ... Small things affect him negatively."

"It scares us, because we are not safe ... Sometimes he wants to burn the house ... I feel unsafe ..."

"By the time we grew up, we used to live a normal life... since his illness and stuff, he has lost focus ...; it created trauma and tension in the family ..."

"My father now gets tired more easily than before ..."

"My father used to smoke normally ... but now he is smoking more and more ..."

Five (21.2%) of them reported to have been constantly depressed while 4 (17.3%) indicated that they developed a health condition of high sugar level. This is what they said about their psychological and physical being:

"... I was diagnosed with sugar diabetes due to my husband's health condition ...", "... he has PTSD, depression, high blood pressure ..."

"... both my parents are now sick ..."

"I am restless at night... my mother has stress and depression and she is left alone because I am working away, my father is too ..." "... I am now being diagnosed with blood sugar diabetes ..."

"I was also diagnosed with a stress disorder. I got admitted at hospital. ... sometimes when i think about it ... I just get depressed."

Four (17.3%) family members reported to have developed a problem of being forgetful. This is what they had to say:

“... I experience forgetfulness and depression; sometimes I get too worried and forget a lot of things, she is working far from home ... this worries me ...”

Only 1 (5.2%) family member reported to have experienced 4 pregnancy miscarriages due to a stress arising from living with a family member who had been diagnosed with PTSD:

“... I had about four pregnancy miscarriages ...”

**Table 5.10 Distribution of the health effects of living with a family member diagnosed with PTSD (N=23)**

Health effect	Frequency	Percentage
Forgetfulness	4	17.3
Trauma and constant worry	9	38.9
Rise in blood sugar level	4	17.3
Pregnancy miscarriages	1	5.2
Depression	5	21.3
<b>Total</b>	<b>23</b>	<b>100.0</b>

### 5.12.2 The social effects of living with a family member diagnosed with PTSD

The analysis in table 5.11 shows that family members who reported to have experienced family and social relationship problems due to living with a member diagnosed with PTSD constituted 7 (32.2%) of the respondents. The following were their responses:

“... we have a lot of family problems, we don't talk a lot ... everyone just come and go, and prefer to be quiet in our bedrooms ... we argue a lot ...”

“... When he has taken the tablets (medication) ... it becomes a problem, it makes him dizzy and he appears to be insane ...”

“... we are not the same family anymore; we fight a lot ...”

Six (29.4%) of them said that they had financial difficulties and as a result could not afford to pay for household needs and school fees and were in a lot of arrears. This is what family members said about their financial statuses:

“... it brought a lot of drawbacks on our family, since he has been on stress; we suffered a lot financially ...”

“It affected him financially, he is now in a lot of debts, sometimes the medical aid funds are depleted and we pay cash ...”

“... as a family, we experience financial challenges; we could not go to college or university because my father was in a lot of debts ...”

“... we left the house that we paid bond, got people to rent it in order to reduce many debts ...” “Our challenge is in terms of development matters at home, we are going slowly in terms of developing our household logistical matters, e.g. renovating and extending our house, we always argue ..., and we run short of money ...”

Further analysis of table 5.11 shows that 5 (19.2%) family members reported a drop in performance, both at school and at work. This is what they said:

“My father’s condition makes me not to concentrate at school ...”

“... it affected the child at school, we got intervention from school, and the child was referred to a school psychologist because she was not coping at school due to the situation at home ...”

Five (19.2%) of them reported to have developed a sense of distrust and constantly got worried about what their future would be like given the situation of living with a family member diagnosed with PTSD. These are their direct reports:

“Our relationship will never be the same again ... I lack trust; I have intense fear ...”

“This health condition kind of stresses me out ... nowadays we are sad most of the time because of his health; we are worried about his wellbeing ...”

“Sometimes he gets angry unnecessarily ... I feel worried...sometimes when I want to ask him something, I hesitate first ...”

“... as a family, we are very worried; it stresses us a lot ...”

**Table 5.11 The social effects of living with a family member diagnosed with PTSD (N=23)**

<b>Effect</b>	<b>Frequency</b>	<b>Percentage</b>
Financial problems	6	29.4
Decline in school and work performance	5	19.2
Family and social relationship problems	7	32.2
Lack of trust, frustration and constant worry and lack of adequate support from the SAPS organisation	5	19.2
<b>Total</b>	<b>23</b>	<b>100.0</b>

### **5.13 FAMILY MEMBERS' COPING WITH THE EFFECTS OF LIVING WITH A MEMBER DIAGNOSED WITH PTSD**

Table 5.12 indicates that 12 (52.8%) of the family members made use of the care and support provided to one another and from friends and the extended family members. The received support included sharing household chores, hiring household helpers, providing food, talking about the condition and how it affected them and ensuring that the member diagnosed with PTSD took medical treatment as prescribed by the doctors. They mentioned the following:

“Being there for each other ... trying to solve matters ... talking to each other and to him also.” “We make sure that He has eaten ...”

Four (17.3%) reported that it was difficult for them to cope with the challenges brought about by having a member diagnosed with PTSD, as a result, they did not really cope with the situation. This is what they reported:

“For me, it is difficult to cope in the family ... I don't know if it is me who is not open to him or what ... There is no improvement, there is communication breakdown, and we never sat down as a family and talk ... I once tried but it didn't succeed.”

“For me, it is difficult to cope with family problems. I now help him a lot because he is weak and cannot do things that he used to do for himself, you see ...”

Attending church together as a family was reported to have sustained 3 (10.8%) of the affected families. They said:

“We cope by praying that things will be better, attending church and practicing religion has kept us where we are today ...”

“... I do my best to encourage my family to attend church together ... we get support there ...”

“By prayer ... I am able to go on with life”.

Two (4.1%) of the family members reported that they found comfort in talking and learning more about PTSD as a health condition and sharing about how to deal with the situation as a family. Here is what they said:

“My family never used to talk ... We used to deal with our problems on our own. Since this situation, we talk together as a family ... We actually have learned from this situation ...”

“We are used to his condition; we are able to identify any changes.”

One (5.2%) family member reported to have used avoidance coping strategies such as not talking to the member diagnosed with PTSD. Here is what he had to say about this aspect:

“... I avoid talking to him, especially when he is angry.”

One (5.2%) of them said that he endeavoured to be resilient in dealing with the effects of living with a family member diagnosed with PTSD. He is quoted below:

“... I try to be strong, I counsel myself. Like some other time when he went to the doctors, I felt depressed, the doctor offered counselling that I have to be strong for my children ...” (Cries...).

**Table 5.12 Distribution of coping mechanisms used by family members to deal with living with a member diagnosed with PTSD (N=23)**

<b>Coping mechanism</b>	<b>Frequency</b>	<b>Percentage</b>
Use of family support	12	56.8
Trying to be strong	1	5.2
Attending church and praying together	3	10.8
Avoidance	1	5.2
Talking to each other	2	4.7
Difficult to cope	4	17.3
<b>Total</b>	<b>23</b>	<b>100.0</b>

## **5.14 FAMILY MEMBERS' OPINIONS AND RECOMMENDATIONS FOR MANAGEMENT OF LIVING WITH A MEMBER DIAGNOSED WITH PTSD**

As shown in table 5.13, most (80.3%) family members are of the view that in order for them to be assisted and supported to manage living with a family member diagnosed with PTSD, the SAPS organisation must offer adequate family counseling services. These should be incorporated with home visits to render required the spiritual, social and psychological support required by families.

Presentation of life skills empowerment programmes such as men and women health and wellness, financial management and family enrichment programmes to families, were perceived to be of critical importance in supporting families. This is what they said to substantiate this aspect:

“Arrange for family visits and support counselling sessions at least once a month ...”

“... psychology does help ... how frequent they offer counselling can also help ...”

“... talking to the families helps because they suffer as much as the patients”

“Support, counsel them, and check if everything is o k...” “Make sure that he gets professional help ..., show that you care, and show that he is still a co-worker ...”

“We also need counselling and as a family ...” “... check up on him if he is coping well at work and do not give him traumatising work again ...”

“They must come and visit him at home or hospital; they must call and check how he is doing because he is part of SAPS ...”

“... Find counselling from SAPS ... Debt counsellors should be there and offer information on debt counselling and arrange financial management sessions for families, help them manage their financial situation ... arrange programmes such as men and women’s programmes, where men and women will talk about issues affecting them, conducted weekly and identify certain problems ...”

Two (4.1%) family members’ raised the view that in order to resolve the problem of family separation caused by job transfers, the SAPS should ensure that families are transferred together and that the EHW personnel should be kept within the organisation. This is what they had to say about these issues:

“... transfer the member to where support is ... to work nearer to her family ...”

“There is a problem of separation ... currently my parents are living far apart because of my father's job placement ... there is no unity ... we need a father figure when we are growing up.”

“... married couples should be transferred together...this issue causes marital and financial problems in homes because we spend too much for where he is transferred to and at home ...”

“... SAPS is losing professional people, but they are not keeping them. They should be empowered and kept within the organisation ... we feel comfortable with people who used to counsel us before as compared to new ones.”

One (5.2%) family member thought that if families could receive study bursaries from the SAPS organisation, they will be financially supported. This is what she had to say:

“... offer bursaries for family members because we try to study and it is not easy having to take care of the PTSD patient/ husband and studying ...”

One (5.2%) member reported that another financial support the SAPS organisation should render to families is by ensuring adequate medical assistance to avoid medical aid funds being exhausted. Here is his comment:

“The SAPS must provide adequate medical assistance, to avoid funds being exhausted, it affects us financially ...”

Offering job promotion and appreciation for hard work commitment and loyalty for the SAPS workers diagnosed with work-related PTSD was viewed by 1 (5.2%) family member as essential. This is his verbal response:

“... He did not get the promotion though he deserved it ...”

“I hear people talk about how much my father worked ... but he does not get rewarded for that ... the issue of lack of promotion contributed a lot to the health condition ...there was no fair treatment.”



**Table 5.13 Family members' opinions and recommendations for the management of living with a family member diagnosed with PTSD (N=23)**

<b>Opinion</b>	<b>Frequency</b>	<b>Percentage</b>
The SAPS organisation must offer combined family counselling sessions, home and hospital visits and life skills empowerment programs	18	80.3
The SAPS organisation must offer study bursaries for families of workers diagnosed with PTSD	1	5.2
The SAPS organisation must transfer workers diagnosed with PTSD near families and retain EHW professionals within the SAPS organisation	2	4.1
The SAPS organisation must ensure adequate medical assistance for workers diagnosed with PTSD	1	5.2
Offer job promotion and hard work reward for workers diagnosed with work-related PTSD	1	5.2
<b>Total</b>	<b>23</b>	<b>100.0</b>

## 5.15 CONCLUSION

This chapter presented and described the findings of the current study on participants' demographic information, work and non-work-related traumatic incidents leading to the development of PTSD. In addition, findings on national and local PTSD prevalence, and the health and social impact that PTSD has on this specific group of workers were documented. Other sections in this chapter captured participants' verbal comments and suggestions on PTSD management. The findings on their coping strategies were also presented in this chapter.

The next chapter discusses inferences drawn on the basis of the current study's findings.

## **CHAPTER 6**

### **DISCUSSION ON RESEARCH FINDINGS**

#### **6.1 INTRODUCTION**

This chapter discusses the findings from the results presented in the previous chapter. The discussion on the findings considers the results from both groups of participants; namely the SAPS workers and their immediate family members. Data is presented in two sections, in which the first section discusses the findings from the SAPS workers and the second focusing on the family members' data.

#### **6.2 RESEARCH DESIGN AND METHOD**

##### **6.2.1 Research purpose**

The purpose of this study was to develop guidelines to assist the SAPS organization to provide appropriate interventions for workers diagnosed with PTSD in the Mahikeng area. Furthermore, the guidelines sought to assist the workers' immediate family members to cope with living with a member diagnosed with PTSD, and ultimately promote both the SAPS workers and the family member's well-being through the provision of a conducive and supportive work and family environments.

#### **6.3 SECTION A: PARTICIPANTS' DISCUSSION OF FINDINGS – DISCUSSION ON RESEARCH FINDINGS**

##### **6.3.1 Participants' demographic characteristics**

A total of 19 SAPS workers participated in this study. All of them, South African nationals, worked in the Mahikeng cluster offices and surrounding police stations and units. Over half of the participants fell within the age group of 40-49 years, while a few were in the 30-39 years age category. The mean age of the participants was 41 years. A majority of the participants were males while few were females. The eldest participant was 54 years while the youngest was 26 years old.

According to the findings, a majority of the participants were Setswana speaking. Very few of the participants had Afrikaans, North Sotho, South Sotho, Xhosa and Tsonga as their home language. Over a third of the participants were at the rank of Warrant Officer, while few were Sergeants and Constables. A minority of the participants were at the

ranks of Colonel, Lieutenant Colonel, Major and Lieutenant. Furthermore, over half of them had more than twenty years of working experience in the SAPS organisation, while a few had worked for less than ten years. A large number of the participants were married. Few participants reported to have never been married. The findings also presented that most participants were African as compared to a minority that belonged to the white ethnic group. The findings also indicated that above a third of the participants had matric qualifications. Some participants indicated that they had obtained Diploma and Degree qualifications, while very few pointed out that they did not have a matric qualification. Finally, all participants belonged to the Christian faith.

## **6.4 PREVALENCE OF PTSD AMONG THE SAPS WORKERS**

### **6.4.1 National PTSD prevalence**

The SAPS national PTSD prevalence rate was found to be at 1.72%. All reported cases of PTSD among the SA police workers were calculated among the number of all police officials in the nine provinces of South Africa (The SAPS organisation Intranet: 2012). On the contrary, findings from an international study by Maia et al (2011:5) which sought to assess predictors of PTSD symptoms among Brazilian police officers reported a higher prevalence rate of 7-19%. Further differing findings among US police indicated a prevalence rate of 6.2% among police workers who were involved in the World Trade Centre disaster (Perrin et al 2007:1). An added contrast to the current finding is evident in the 17% PTSD prevalence rate observed among the US military veterans who served in Iraq and Afghanistan, while for those who served in Vietnam it was between 15-30% (Florida institute for family violence studies:2011:20).

### **6.4.2 Local PTSD prevalence**

Current findings yielded an average level (0.76%) of PTSD prevalence in the Mahikeng area. Findings from Stromnes' (1999:1) quantitative study on police officers in KwaZulu-Natal showed a 12%-35% prevalence rate of PTSD, while Edwards (2005:132) found a prevalence rate of 36% amongst the riot police in Cape Town and in the Eastern Cape Province, and that of 41% among black police in Soweto and Pretoria.

## **6.5 TRAUMATIC INCIDENTS LEADING TO A POSSIBLE PTSD DEVELOPMENT**

### **6.5.1 Categories of traumatic incidents for possible PTSD development: work and non-work-related incidents**

The present study indicated that a large number of the participants reported exposure to work-related traumatic incidents as compared to a minority of them who reported exposure to non-work-related traumatic incidents. This finding concurs with findings from records reviewed with the local referring specialist psychiatrist, which related to the SAPS workers' exposure to work-related traumatic incidents and their link to possible PTSD development. On the contrary, findings documented locally in a study conducted by Young et al (2012:30) which explored how trauma experienced by the SAPS workers was constructed or "talked about" and made sense of, indicated that the experience of traumatic stress is not solely the result of work-related traumatic experiences the SAPS workers constantly get exposed to, but was instead the result of both the traumatic experiences and systems psychodynamics operating within the SAPS organisation, including both organisational stressors and transformation stressors. Internationally, several similar studies were conducted by Tehrani (2011:63), Rosen et al (2011:36), Garbarino et al (2011:395) and Leino et al (2011:400) about police officials and security officials in the USA. These studies found that constant exposure to work-related traumatic incidents such as experiencing or witnessing a gruesome incident, experiencing gross physical injury, involvement in war combat; recovering bodies from motor vehicle accidents and disasters such as plane crashes; being the victim of abuse, rape, robbery; and involvement in civil conflicts during service delivery protests has an immense undesired impact on the psychological being of the police and security workforce and to made them highly vulnerable to PTSD development.

#### ***6.5.1.1 Participants' experiences of work-related traumatic incidents and their contribution to possible PTSD development***

Almost a third of the participants reported to have been exposed to shooting, rape and gruesome murder scenes. On the same breath, almost a third of them have seen colleagues and community members who committed suicide. Only a few participants were exposed to prisoner escapes. Similarly, findings in a study conducted by Tehrani (2011:25) on the USA police conducting specialised and high risk roles, including family liaison forensic and firearm and body recovery work, documented that over identification with victims or the families of victims of crime led to increased risk of developing PTSD

among the workers. Findings from studies conducted on the SAPS workers in the Gauteng, KwaZulu-Natal and Limpopo Provinces by Van Den Heever (2013:1), Young et al (2012:4), Chabalala (2005:46) and Edwards (2005:132) documented high risks of PTSD diagnosis among the SAPS workers who are frequently exposed to work-related trauma such as death of colleagues, attending to gruesome scenes of murder, shooting, hostage situations and conducting police specialised roles including forensic and intervention work.

#### ***6.5.1.2 Participants' experiences of non-work-related traumatic incidents and their contribution to possible PTSD development***

The present study found that a minority group of the participants experienced non-work-related trauma emanating from marital, family, social and loss of loved ones, parents and life partner; extensive exposure to an abusive marital relationship; deceit in relationships; and suicide of the SAPS worker's child. The SAPS workers' experiences of non-work-related traumatic incidents was in line with Jonker (2011:2), Olivier (2009:45), Young (2003:38), and Maabela (2011:1)'s findings on police workers in Gauteng and North-west Provinces that, while the police workers were exposed to occupational trauma, numerous stressors and traumatic incidents arising from personal and socio-economic spheres of their lives such as being the victim of rape or assault, loss of loved ones, financial problems, involvement in personal motor vehicle accidents, and encountered social and family relationship problems, they also experienced constant fear and anxiety.

The five key findings on the participants' experiences of work and non-work-related traumatic incidents discussed above have been used with the relevant element/s of the theoretical framework guiding this study, namely the Wits Trauma Model (WTM) for the development of the guidelines for the management of PTSD in Mahikeng area. The developed guidelines are presented in chapter 8 of the current report.

The WTM offers effective trauma management tools essential to addressing subjective elements of trauma and PTSD (Sibisi 1999:12). Its integrative, structured and problem oriented nature acknowledges that trauma impacts on the person's internal (cognitive) and external (behavioral) psychological functioning (Hajiyiannis & Robertson 1999:4). Therefore, PTSD management requires a treatment approach which will address these two vital areas of human functioning. Furthermore, the WTM interrelate therapeutic techniques originating within both the psychodynamic and cognitive-behavioral

processes in order to influence development, maintenance and prevention of PTSD (Hajjiannis et al 1999:4). Therefore, integrating both techniques will assist the SAPS workers with the management of the health condition.

In acknowledging that trauma experienced by the participants emanated from various areas of life, including work, personal, social and family settings, and that trauma also impacted on the participants' cognitive and behavioral functioning, the above study findings on exposure to work and non-work-related traumatic incidents were related to the two components of the WTM. These two components of the WTM are telling / retelling the traumatic story and addressing survivor guilt which point to the importance of ventilating about the impact of trauma stemming from various spheres of life. Therefore, obtaining professional services for work and non-work-related traumatic incidents is essential.

These components of the WTM further emphasises the value of giving psychological attention to traumatic reactions, including self-blame and guilt feelings, normally experienced after exposure to trauma (Eagle 1998:139). Therefore, creating a supportive environment through offering trauma counseling using the WTM to the SAPS workers will enable catharsis of the health and social effects of living with PTSD and thus relieve and lessen the traumatic reactions and contribute positively to PTSD management.

## **6.6 EFFECTS OF PTSD AMONG PARTICIPANTS**

### **6.6.1 Health effects of PTSD among participants**

Current findings indicated that living with PTSD was related to emotional, behavioral, as well as mental effects experienced by participants. Most of them reported that they had experienced lack of sleep due to re-lived traumatic memories and persistent nightmares and anxiety. A few of the participants indicated that they became short-tempered and easily annoyed while interacting with other people in their work, social and family settings. Furthermore, a few of them became suspicious that other people were conniving and plotting against them and therefore became mistrusting, especially towards strangers.

A minority of participants in the current study linked the development of health conditions, including high blood pressure, knee pains and nervous breakdown, to the negative stress experienced as a result of being diagnosed with PTSD. In addition, a

few indicated that they solely relied on psychiatric medication for daily functioning. Similar findings from local studies conducted among police workers in the North-West and Limpopo Provinces of South Africa by Sekwena et al (2007:37) and Madu et al (2006:213), respectively, and international studies conducted on police workers in the USA by Brown (2012:1) and Roberts et al (2011: 73), attributed trauma victims' physical, social and mental impairments, including heart disease, anger, alcohol and drug dependence and abuse, domestic violence, hypertension, migraines, reduced immunity, suicidal tendencies, and anxiety, to constant exposure to work-related trauma and PTSD.

Further findings from a qualitative study by Rajin (2012:5), which investigated the implementation of the SAPS EAP (EHWP) among police and the SAPS EHW workers in Soweto's Moroka Police station in the Gauteng Province of South Africa noted that constant and extreme exposure to traumatic incidents without counseling may lead to PTSD and employees' decreased job fulfillment.

#### **6.6.2 Social effects of PTSD among participants**

The findings showed that most of the participants linked the negative experiences on their social and family relations to living with PTSD. About two thirds alluded that they lost interest in their friends and did not relate with them as they used to prior to being diagnosed with PTSD. Furthermore, close to a third of the participants indicated that they stopped participating in public networks. Similarly, international studies which focused on the health and social effects of PTSD among the military veterans and their immediate family members in the USA documented that avoiding interactions and detaching oneself from others, especially family members, health and mental professionals and friends, had undesirable effects on the veterans' wellbeing and relations with others (Tehrani 2011:1; Ray et al 2011:3; the US Department of veterans' affairs 2011:59; Brown 2012:2).

Furthermore, few participants were of the perception that their friends and co-workers were not giving them the necessary care needed during their ill health times. Inadequate provision of relevant information to manage the administrative part of leave of absence due to PTSD; specifically by the HRM professionals, and non-visitation at home or hospital by colleagues and friends during ill health periods were reported. Internationally, findings among police workers in the USA which assessed the effect of perceived social support and coping among the victims of trauma, conducted by Walter

(2011:2), Pfeifer (2011:18) and Klaric et al (2008:466), reported on and emphasised the value of receiving support from significant others including family members, friends and co-workers. Lack of social support may also lead to feelings of rejection and abandonment being experienced by the person living with PTSD (Walter 2011:2; Pfeifer 2011:18; Klaric et al 2008:466). Locally, studies conducted among the SAPS workers in KwaZulu-Natal and Limpopo Provinces by Pillay (2008:22), Gumani (2012:390) and Van Lelyveld (2008:12) yielded findings indicating the importance of immediate commanders, administrative personnel, senior management and co-workers' offering traumatised workers and workers living with PTSD work place support.

In terms of the WTM, the findings on the health and social effects of PTSD relate to the component of normalising the traumatic symptoms. This calls for the rendering of psycho-education about post-traumatic stress symptoms, acknowledging the cognitive and behavioral impact of trauma on an individual SAPS worker and reassurance of the normalcy of experiencing such traumatic symptoms as well as re-living the trauma, misperceptions about friends and co-workers and withdrawal symptoms. This is crucial as it will assist the affected to seek early professional intervention and treatment and therefore promote the management of PTSD (Eagle 1998:140).

## **6.7 PARTICIPANTS' COPING MECHANISMS TO DEAL WITH PTSD**

The findings revealed that above a third of the participants utilised the physical care and support such as being accompanied to the health and mental institutions for consultations, obtaining psychiatric medication and ensuring that they take the medication as prescribed. The participants also reported that they were provided with human basic needs such as food and a hygienic and conducive home environment. With regard to emotional support, aspects such as receiving empathy and being listened to when they share their traumatic experiences to friends and family members were also indicated in the current findings. Socially, the encouragement to partake in hobbies and attending and partaking in social and family events were reported to have assisted participants to cope with the health and social effects of PTSD.

Similar findings from studies conducted among war and post war traumatised women in Bosnia and Herzegovina by Klaric et al (2008:466) indicated that talking about problems with loved ones and receiving social, emotional and physical support from friends, family members and co-workers played a significant role in coping with trauma and



PTSD. By the same token, findings from studies on the SAPS workers and Metro police workers in the Gauteng province by Chabalala (2005:71) and Kgalema (2002:18) emphasised that social and family support is essential in coping with trauma and PTSD. Further findings of studies among police workers in the KwaZulu-Natal and Limpopo Provinces conducted by Pillay (2008:21) and Gumani (2012:382) asserted that the trust and faith entrenched in family members and friends allows for ventilation of emotional tension caused by traumatic incidents experienced by police workers and thus assist in coping with trauma and PTSD. A few of the participants used guidelines obtained from counseling services received from internal and external professionals to cope with the effects of PTSD. Locally, similar findings from a qualitative study conducted among police officers in Limpopo Province by Gumani (2012:382) reported that using professional counseling and guidance received internally, from the SAPS EHW personnel and externally from medical doctors, social workers and psychologists enabled effective coping with trauma and PTSD within work, social and family settings. Internationally, similar findings from a qualitative study among police officers in the USA who specialised in conducting high risk roles were documented by (Tehrani 2011:17). The findings indicated that obtaining confidential personal support from an occupational health nurse or from a counselor, to deal with family issues impacting negatively on work performance and on families, helped on coping with the effects of trauma and PTSD (Tehrani 2011:17).

Current findings indicated that few of the participants engaged in hobbies in order to cope with the effects of PTSD. These hobbies included actively participating in sports, physical exercise, engaging in art and wood work as well as going for shopping. Similarly findings from qualitative studies conducted among police officers in Polokwane, and the Vhembe District of the Limpopo Province of South Africa by Mabe (2004:64) and Gumani (2012:142) reported that actively partaking in physical activities and hobbies promotes mental and physical wellness and effective coping with trauma and PTSD.

Current findings indicated that a minority of participants avoided interacting with friends and also avoided the memories and feelings related to the trauma. Findings in a study which sought to describe inner strategies of coping with operational work amongst SAPS workers in the Limpopo Province, conducted by Gumani, Fourie and Terre Blanche (2013:4), found that coping strategies that were used centered on problem-focused and emotion-focused strategies with some use of re-appraisal and minimal use

of avoidance. Further findings from local studies conducted on police workers in the Limpopo and the Eastern Cape Provinces of South Africa by Myendeki (2008:9), Young (2005:75) and Mabe (2004:34), focused on the use of avoidance coping mechanism to psychological stress and poor wellbeing. Internationally, studies on police in the USA, conducted by Taylor (2008:1) and Emmelkamp et al (2002:1465) viewed the use of avoidance coping strategy as ineffective and delaying the trauma recovery process as it involves denial and avoidance of trauma inducing events.

Few of the participants in the current study reported to have coped with the effects of PTSD by telling themselves that they are obliged to serve in the police service and thus persevered in their work, despite the hardships, for the sake of their families. Similarly, findings from Gumani's (2012:328) study on the SAPS workers in the Limpopo Province indicated that workers felt obliged to do their work and persevered for the subsistence of their loved ones.

Few participants engaged in religious practices such as attending church and praying together as a family for spiritual deliverance. Similar outcomes from local studies conducted among the SAPS workers in all nine Provinces and the SAPS Head office, reported positive contributions arising from establishing and maintaining religion to cope with PTSD (Joubert et al 2013:2; Gumani 2012:328; Young 2005:164; Gumani et al 2013:12). Moreover, findings from a study conducted on the SAPS workers in the Limpopo Province by Gumani (2012:330) showed that workers viewed engaging in religious practices as most significant in their work, social and family lives and also assisted them to understand traumatic situations in a spiritual context. This also helped the workers to achieve spiritual strength and self-sufficiency in coping with trauma and PTSD.

Internationally, a study conducted by Clark-Miller and Brady (2012:2) to evaluate the ability of religion to mitigate harmful consequences of critical stress among 811 Metropolitan police officers in the USA revealed the positive role played by religion in the maintenance of physiological and psychological wellbeing. Furthermore, it was found that prayer lowers blood pressure, enhances immune function and reduces anxiety (Clark et al 2012:2).

Very few participants reported that they consumed alcohol to avoid and repress experienced traumatic memories and feelings of fear, anxiety and of always being suspicious to other people. Similar findings from studies conducted among police

workers in the Limpopo and Gauteng Provinces of South Africa and in the USA by Young et al (2012:5), Madu et al (2006:216), Lynch (2007:1) and Young (2005:76) indicated that some of the police workers used alcohol to inhibit trauma related reactions such as hurting thoughts, worry, and distrust.

Current findings on coping with PTSD in various areas of functioning concurred with the WTM's component of promoting mastery of traumatic symptoms, which recognises and emphasises the importance of having effective coping mechanisms in place to successfully manage the effects of trauma and PTSD (Eagle 1998:142). Rendering trauma counseling using the WTM will therefore take the SAPS workers living with PTSD through a therapeutic process. This therapeutic process would use the psycho-dynamic and cognitive-behavioral approach which aims at facilitating the development of coping skills and support the individual worker to identify and correct cognitive distortions and attributions of meaning from their traumatic experiences (Hajjiyiannis et al 1998:4).

Furthermore, using the WTM will provide an opportunity for the workers to be equipped with more knowledge and skills on adaptive and maladaptive coping strategies to help master the traumatic symptoms. The individual SAPS worker's ability to develop new convictions, meaning and direction in life, normally yields positive outcomes, such as greater agency, self-management and restored feelings of assertiveness and competence (Sibisi1999:72), and ultimately assist in the management of PTSD.

## **6.8 AVAILABLE ONSITE OCCUPATIONAL HEALTH INTERVENTIONS FOR THE MANAGEMENT OF WORKERS WITH PTSD**

Reviewed records from the study site indicated that the following support programmes were implemented to manage PTSD at the study site:

### **6.8.1 Primary prevention**

#### **6.8.1.1 *Induction training***

All new police recruits are taken through a training process that provides information on the factual nature of police work. The training process is psychologically and physically demanding and traumatising in order to create awareness and to help equip the police recruits, at an early stage, with essential knowledge and skills that will assist in managing the negative effects of trauma they will be exposed to when they conduct

operational police work at various stations. In addition, the induction process is directed at enabling the workers to counteract possible PTSD development later in the course of their work within the SAPS organisation. Similar findings among police workers in South Africa by Gumani (2012:133) and in the USA by Tehrani (2011:223) documented that police induction training aims at preparing workers with the very traumatising nature of the police environment, and further highlighted that the implementation of effective trauma management techniques is essential in preparing the recruits mentally.

#### **6.8.1.2 Life skills training**

This programme is provided to all new police trainees on a quarterly basis at all police training institutions. The training is also provided to those workers at police station levels who are already doing operational field and office work to empower them with essential knowledge on how to cope with personal, work, social and family life challenges. The programme also aims at enabling best work performance among the workers. Findings from Gumani's (2012:133) study on police workers in the Limpopo Province by similarly indicated the importance of engaging internal and external professional service providers, such as mental health workers, to educate police workers on critical psycho-social matters affecting them on a daily basis.

#### **6.8.1.3 Marketing of EHW services and awareness information about PTSD**

This programme involves the provision of awareness and information sharing about the services provided by the SAPS EHWP. Reviewed records indicated that health and wellness promotion and education is done through the distribution of pamphlets at various work stations, dissemination through the SAPS intranet, face to face presentation sessions and usage of educational and promotional posters at the study site. However, the face to face marketing of services presentations to all police stations and units in and around Mahikeng area is inadequate due to insufficient EHW personnel that render these services. As a result, some of the workers are not aware of the available EHW services. Findings from Rajin's (2012:56) study on the SAPS EHW and police workers in Moroka Police station in the Gauteng Province reported on the importance of creating awareness about EHW services among police workers and that most of the police workers were aware of the SAPS EHW services. On the contrary, findings from Gumani's (2012:371) study reported that police workers in the Limpopo Province's Vhembe District lacked an awareness of the existing debriefing services.

#### **6.8.1.4 *The SAPS EHW wellness days***

The SAPS worker's health and physical wellness and fitness is ensured through the implementation of this programme. Sport, recreational and indigenous games and health assessments by the POLMED health professionals form part of the wellness events within the SAPS organisation. Findings among various workplaces in the USA by Rogers (2011:1), Hart (2012:4) and Bennet (2010:3) have documented enhanced employee performance, team spirit building and maintenance among workers and managers that are achieved through regular active participation in employee wellness sport, health and recreational activities. Reviewed records indicated inadequate implementation of the programme due to inadequate EHW personnel. Therefore, capacitating the EHW unit will immensely enhance employee wellness and job performance.

### **6.8.2 Secondary prevention**

#### **6.8.2.1 *Initial debriefing/defusing***

This is a psychological support programme conducted by immediate commanders and trauma debriefers to render immediate support after exposure to trauma. The support programme is also used to refer trauma debriefers for further psychological services, for the management of trauma and to curb the development of other health conditions, including PTSD. Findings from qualitative studies conducted on police workers in the Gauteng Province by Chabalala (2005:52) and Maabela's (2011:27) in the North-west Province emphasised the importance of conducting initial debriefing immediately after the traumatic incident or before the end of the particular shift in order to provide immediate support and to establish team solidarity among the traumatised workers. Records reviewed further showed insufficient implementation of this service due to experienced lack of commitment to render initial debriefing services by trained commanders and insufficient EHW trauma debriefers in the Mahikeng area. There is a need to retrain trauma debriefers and to solicit their commitment to rendering this essential service in order to support affected workers who will ultimately perform better and thereby contribute positively to the organization so that it realises its set goals.

Similar findings in Gumani's (2012:263) study conducted among police workers in the Limpopo Province indicated that debriefing services were not offered to all of the police stations in the Limpopo Province. Hence, some police workers for whom debriefing

services were non-existent at their police stations implemented “self-care” coping strategies, thus utilising support from colleagues and spouses to curb psychological ailments due to constant exposure to trauma.

#### **6.8.2.3 Formal debriefing**

This service is rendered by trauma debriefers within 72 hours of exposure to trauma to maintain team solidarity and equip traumatised workers with effective coping mechanisms. Findings from a study by Van Wyk et al (2005:138), which focused on police workers in the Gauteng and Gumani’s (2012:264) in the Limpopo province showed that trauma debriefing was experienced and perceived as unsatisfactory, unnecessary and a waste of time. In contrast, findings from Van Den Heever’s (2013:50) and Chabalala’s (2005:80) studies on police workers in the Gauteng Province and by Maabela (2011:56) in the North-West Province documented positive experiences and views about trauma the debriefing programme. Record reviews also indicated an insufficient implementation of this programme due to a shortage of trauma debriefers in the Mahikeng area. Similarly, findings from studies conducted by Gumani (2012:136) on police workers in the Limpopo Province and by Van Wyk (2011:2) in the Gauteng Province identified lack of adequate trauma debriefers as a shortcoming for this programme.

#### **6.8.2.4 Psycho-social, spiritual counseling, hospital and home visit services**

The programme offers support sessions to workers on how to manage trauma and PTSD as well as other stressors. From the reviewed records, the counseling services were found to have been extended to some of the SAPS workers’ immediate family members with little or no follow up services due to inadequate EHW personnel. Findings from a study by Tehrani (2011:17) focusing on police workers in the USA and findings from Rajin’s (2012:2) study on police workers in South Africa’s Gauteng Province showed that encouraging clients and making them aware of the benefits of talking about personal, social and traumatic experiences offers a useful opportunity to ventilate and serve as an indication that the employer and managers/ commanders care about the occupational health and wellbeing of their employees.

#### **6.8.2.5 Multiple Stressor Debriefing (MSD)**

This programme provides opportunity to the SAPS workers who are specifically working at the specialised high risk units that are constantly exposed to trauma to talk about various stressors.

Various activities, including relaxation exercises, form part of the SAPS organisation's MSD programme. Van Den Heever (2013:52) asserted in a study which evaluated the effectiveness of the SAPS multiple stressor programme among the SAPS workers in the National Intervention Unit (NIU) in Pretoria that this trauma intervention and management programme focuses on addressing trauma and stressors over a longer period of time. The reviewed records further attributed insufficient implementation of the MSD programme in Mahikeng area to a shortage of EHW professionals. Findings from studies conducted among the American Red Cross personnel in the US reported positive outcomes using the multiple stressor model among the relief personnel who had been exposed to a multitude of stressors (Armstrong, O'Callahan & Marmar 2006:4; Armstrong, Lund, Mc Wright & Tichenor 1993:2). On the contrary, findings from a study conducted by Van Den Heever (2013:1) focusing on 22 SAPS workers based at the NIU in Pretoria, which assessed whether this trauma management programme prevents or reduces PTSD symptoms, showed that the SAPS organisation's multiple stressor trauma intervention programme lacks scientific evidence to support its possible effectiveness in managing PTSD.

#### **6.8.2.6 A 24 hour crisis intervention and stand-by service**

The 24 hour stand-by service is rendered on a continuous basis by alternating EHW professionals who are always on stand-by to render psycho-social and spiritual services in Mahikeng and its cluster police stations. Ford (2009:275) documented the importance of rendering this service to address workers' crisis situations. Findings from studies conducted on police workers in the Limpopo Province by Mokgobu (2010:2), Gumani (2012:264) and Mabe (2004:65) documented the reluctance and unwillingness by traumatised and stressed policemen to utilise the 24 hour crisis and counseling service owing to the stigma attached to the SAPS EHW personnel. On the contrary, findings on the SAPS workers in the Gauteng province conducted by Van Wyk et al (2005:138) and Kopel et al (1997:307) attributed inadequate use of the 24 hour crisis intervention and support services to the macho culture held by some of the SAPS workers.

### **6.8.2.7 *The SAPS EHW National Call Centre***

This is a 24 hour emergency and counseling programme operating from the SAPS Head Quarters in Pretoria. The SAPS workers from all provinces are at liberty to use this support service which also serves as a referral port for workers belonging to other provinces. Reviewed records showed that referrals are occasionally received by the Mahikeng EHW personnel from the National call centre. Findings on police workers in the Gauteng Province by Seanego (2012:1) and in the KwaZulu-Natal Province by Pillay (2008:22) associated inadequate utilisation of this programme to the shame of seeking professional help.

### **6.8.3 Tertiary prevention**

#### **6.8.3.1 *PTSD support group***

This is a service aimed at allowing workers diagnosed with PTSD to share their traumatic experiences in a therapeutic group setting and obtain support and establish solidarity in managing the health condition. According to the records reviewed, only one PTSD support group is active in the SAPS North-West province, furthermore the findings indicate that there was no support group at the study site. Findings from the reviewed records attributed this finding to inadequate EHW personnel, hence the failure to facilitate support groups at various work sites within the province.

The findings further showed that none of the Mahikeng SAPS workers diagnosed with PTSD formed part of the support group which is only facilitated from the provincial offices located in Potchefstroom. Lack of participation in the support group by the Mahikeng SAPS workers was mainly attributed to logistical problems and lack of transport to travel to the SAPS North-west Provincial office. Findings from studies conducted internationally on police workers and military veterans in the USA by Martz et al (2010:27) and Tull (2010:3), and findings from studies conducted locally by Young (2005:73) in the Gauteng Province and by Mabe (2004:36) in the Limpopo Province acknowledged the powerful role of support groups in assisting workers to deal with life challenges, trauma and PTSD.

#### **6.8.3.2 *The SAPS Sports programme***

The SAPS sports programme consists of a variety of physical and mental activities aimed at encouraging healthy and active lifestyles. These sports activities enhance



stress and PTSD management and promote resilience in the workplace and in life in general. Record reviews indicated inadequate participation of workers in this programme in the Mahikeng cluster due to dilapidated sport complex, lack of sport gear and equipment and the general inadequacy of resources at the study site.

Findings on police workers and the general public in the USA reported the importance of partaking in the workplace sports programmes such as sports Wednesdays within the organisations as well as health and wellness events packed with sport activities (Tulloh 2012:1; Rogers 2011:1; Hart 2012:4; Bennet 2010:3). Furthermore, actively partaking in sport is associated highly with psychological and physical wellness and the effective management of trauma and PTSD (Tulloh 2012:1; Rogers 2011:1; Hart 2012:4; Bennet 2010:3).

#### **6.8.3.3 *The POLMED Psychiatric disease management programme***

This service aims at supporting the SAPS workers diagnosed with PTSD by providing information on disease management. The programme also seeks to establish and maintain contact with the workers' treating health professionals. Periodic monitoring of the SAPS workers' adherence to PTSD medical treatment through telephonic follow up sessions forms part of this support programme. Findings from the reviewed records indicated that a minority of the participants received periodic telephonic support from the POLMED Psychiatric program, which served as check up on their health and wellbeing as well as follow up on psychiatric medical treatment adherence and progress. Studies conducted on police workers in South Africa by Young (2003:38), Pillay (2008:22), Gumani (2012:263) and Seanego (2012:1) and in the USA by Tehrani (2011:19), reported on the impact of workers' biased perceptions on receiving counseling services and on the closed and macho police culture which does not allow the seeking of professional assistance, thus leading to inadequate use of the police Psychiatric Disease Risk Management Programme.

Current findings on available onsite occupational health programmes pertain to the component of promoting mastery of traumatic reactions in the WTM, which encourages trauma victims to mobilise support systems and to share their traumatic story with significant, supportive counterparts (Eagle 1998:142). Therefore, readily available and accessible workplace programmes serve as intervention tools and support systems for workers diagnosed with PTSD, and create an enabling, safe and conducive environment to manage the reactions and effects experienced due to PTSD.

The provision of adequate occupational health and wellness management programmes will therefore enhance job performance, instill the sense that one is being acknowledged by the employer for the contribution made to the organisation and ultimately bring about a sense of job fulfillment and attainment of set organisational goals. In the same breath, the provision of care and support by the employer will help the SAPS workers with regards to PTSD management.

## **6.9 PARTICIPANTS' OPINIONS AND RECOMMENDATIONS FOR PTSD MANAGEMENT**

The majority of participants reported the need for the provision of adequate care and support through extended counseling services to families, home and hospital visits, adequate trauma debriefing services when required, and workplace support by fellow colleagues and immediate commanders to enable coping with the effects of PTSD. Similar findings in a study conducted by Gumani (2012:263) among police workers in the Limpopo Province emphasised the importance of having support from immediate commanders and colleagues, and indicated that received commander support allowed workers to share operational work experiences and obtain advice on how to strategically handle challenging cases. Commander support was also found to have relieved distress and pressures among police workers (Gumani 2012:263).

Furthermore, colleague support enabled discussions on experiences and perceptions among police workers within the same ranks and on how to collectively handle specific traumatic cases to build up enough evidence that would be used in a court of law. Team solidarity was also established through peer support at work (Gumani 2012:259).

Findings from a study conducted by Gumani (2012:258) on police workers in the Limpopo Province noted the positive contribution made by receiving joint family support and counseling sessions. The study also found out that workers got close to their wives due to their ability to self-disclose after sharing their traumatic experiences with their families, (Gumani 2012:258).

In the current study, the majority of participants linked the need for adequate psycho-social and spiritual services to the necessity to capacitate the EHW personnel in the Mahikeng area in order to enable the offering of sufficient integrated family counseling and debriefing services, hospital and home visits to all of the workers affected by PTSD. Findings from studies conducted on police workers in the Gauteng Province by Young

(2005:30) and Van Wyk (2011:2), in the Limpopo Province by Gumani (2012:136) and in the North West Province by Jorgensen (1999:2) noted and documented the shortage of EHW and trauma debriefers within the SAPS organisation, which lead to inadequate psycho-social and spiritual services rendered to the SAPS workers.

Most participants viewed the provision of information sessions about PTSD to their fellow colleagues in order to avoid the stigmatising and labeling of workers living with PTSD. Similar findings were also noted by Reardon (2009:1) in a study on workers with PTSD, who returned back from the Iraq and Afghanistan conflicts. Reardon's (2009:1) study examined work-related support structures for workers diagnosed with PTSD and focussed mainly on the employer's expectations from the workers with PTSD and how the employer could support the workers.

The findings in the study by Reardon (2009:1) documented key roles that must be played by employers and fellow colleagues and these include being educated and aware of challenges associated with PTSD; being informed about the PTSD condition, the symptoms, the effect of the reactions on the worker's work, social, family and personal lives; and being aware of the triggers of the symptoms. These roles were reported as critical in order for one to know how best to render the required support (Reardon 2009:1).

Current findings showed that some of the participants viewed the establishment and maintenance of PTSD support groups in the Mahikeng cluster as important in helping them deal with PTSD. Findings from a study conducted among serving and retired police and emergency workers in Australia indicated the benefits of being part of a police post trauma support group which aims at providing support to those suffering from PTSD, anxiety, depression and the reduction of stigma associated with being diagnosed with these health conditions (Russell 2008:2). Similarly, findings in a study by Tull (2013:6) conducted on families living with a member diagnosed with PTSD, in the USA, documented the pivotal role played by families forming part of support groups as this enhances communication among family members, which is an essential element in managing PTSD.

Active participation in occupational sporting activities was reported by a minority of the participants as crucial in managing PTSD. Similar findings among the USA combat veterans diagnosed with PTSD indicated that sport and physical activity enhances subjective wellbeing in veterans through active coping (Caddick & Smith 2013:2).

Furthermore, active participation in sports was reported to have led to PTSD symptom reduction, positive affective experience and improved quality of life and psychological wellbeing, as well as the constitution of high levels of determination and inner strength, sense of achievement and motivation for living (Caddick & Smith 2013:2).

Few of the participants in the current study recommended marketing and referral for EHW services by commanders as critical in managing PTSD. Similar findings from a study by Reardon (2009:50) conducted among military veterans reported on the importance of employers informing workers diagnosed with PTSD about available internal professional services and referring them to the EAP, as well as the importance of allowing the workers time to go for counseling.

Very few participants viewed alternative job placement and reduced work load as a necessary support mechanism rendered by the employer to enable coping with living with PTSD. Findings from a study by Reardon (2009:3) pointed to the importance of the employer in conjunction with Human Resource professionals making reasonable workplace adjustments and accommodation, including reducing their workload, to help and support workers with PTSD. Furthermore, placing workers in a job environment that will not re-traumatise them, providing them with additional time to learn new responsibilities, allowing them to work from home part time, provision of straight shift work and allowing for more or frequent work breaks, assisting with time management and completing tasks was documented as fundamental to PTSD management (Reardon (2009:3).

In the current study, very few participants viewed job transfers nearer to families as an essential employer support strategy. Findings from studies conducted on police workers in the KwaZulu-Natal Province by Pillay (2008:22), in the Gauteng Province by Young et al (2012:10) and in the Limpopo Province by Mabe (2004:63) highlighted the importance of workers receiving support at work. This includes approval of workers' job transfers to work closer to families for the required social support and also indicated the care provided by the employer and enhanced workers' health and wellness (Pillay 2008:22; Van Lelyveld 2008:12; Young et al 2012:10; Mabe 2004:63).

Current findings showed that very few participants viewed the approval of their ill health retirement application as a necessary means of support to assist them in effectively manage living with PTSD. Findings from studies on police workers in the Gauteng Province by Young et al (2012:10), and in the Limpopo Province by Mabe (2004:63)

indicated that feeling supported in the work environment; including management empathising and taking into consideration the effect of trauma and PTSD on the workers, and relieving them off their duties through medical boarding due to PTSD, was fundamental in managing trauma and PTSD.

In the current study, very few participants reported the need for the provision of job promotion and reward for hard work and dedication on police work. Similar findings documented by Reardon (2009:7) indicated the value of providing positive reinforcement in the workplace to workers living with PTSD in order to enhance their morale and self confidence. Further findings from a study conducted on police workers in the Gauteng Province by Young et al (2012:10) asserted that being recognised for contribution made in the work environment alleviates feelings of vulnerability, acts as a trauma membrane and enables coping with living with PTSD.

Current findings showed that a minority of participants wished for their workload to be reduced. In a study on workers diagnosed with PTSD, Reardon (2009:5) pointed out the importance of making reasonable accommodation to workers diagnosed with PTSD in the USA, highlighting aspects such as ensuring a less stressful workload, providing allowance for a flexible start and end time or work from home and allowing the employees to work one consistent schedule with frequent stretch breaks during work day.

The above findings on participants' opinions and recommendations for PTSD management relates to the two components of promoting mastery of traumatic symptoms and facilitation of creation of meaning in the WTM. Therefore, with the necessary support rendered to the workers, problems such as anxiety, avoidance of traumatic stimuli and regression shall be managed and thus feelings of self- efficacy, and self-reinforcement (Eagle1998:143) shall be experienced thus bringing about a sense of greater assurance and control in managing PTSD among the SAPS workers.

The facilitation of the creation of the meaning component emphasises that participants should be assisted through counseling processes, to view themselves as survivors rather than victims of trauma, which ultimately promotes a hopeful future orientation with greater meaning and a sense of new whole being (Eagle 1998:143). Furthermore, considering and implementing the worker's recommendations will enable workers diagnosed with PTSD to recognise the support rendered by the SAPS organisation and

bring about a sense of being cared for, listened to, appreciated and empathised with among individual SAPS workers and ultimately lead to PTSD management.

## **6.10 SECTION B: FAMILY MEMBERS' FINDINGS – FAMILY MEMBERS' DEMOGRAPHIC CHARACTERISTICS**

A total number of 23 family members participated in the current study. Findings indicated that a large proportion of family members were the SAPS workers' dependents and these were 15 years and older. Few family members in the current study were spouses and parents to the SAPS workers. A minority of them were siblings to the SAPS workers diagnosed with PTSD.

## **6.11 THE EFFECTS OF LIVING WITH A FAMILY MEMBER DIAGNOSED WITH PTSD**

### **6.11.1 Health effects of living with a family member diagnosed with PTSD**

The current findings indicated that a majority of family member's experienced physical and psychological conditions including depression, hypertension, and a rise in blood sugar levels, forgetfulness, pregnancy miscarriages and tense muscles owing to challenges and constant negative stress experienced by families due to living with a member diagnosed with PTSD. The findings documented in a study conducted on the wives of the Israeli veterans living with PTSD by Price and Stevens (2014:7) found more mental health symptoms such as lower levels of happiness and significantly reduced satisfaction with life, difficulty coping with their partner's PTSD symptoms compared to wives of veterans without PTSD (Price & Stevens 2014:7).

Furthermore, over a third of the family members experienced continuous trauma and worry due to a PTSD sufferer's changing moods, unpredictable behaviors and changing habits. Similar findings from a study conducted on 58 spouses of veterans with PTSD to establish the relationship between the severity of the veterans' PTSD symptoms and caregiver worry and distress (Tull 2014:4) documented unhappiness, worry and difficulty in understanding the PTSD sufferer's changeable behaviour.

### **6.11.2 Social effects of living with a family member diagnosed with PTSD**

The negative effects of PTSD spilling onto social and family relations were mentioned by over a third of the family members who indicated having experienced family and friendship problems such as detached families, withdrawal from friends and avoidance

of social gatherings. The difficulties were linked to over exposure to emotional and psychologically straining situations such as mood swings, lack of trust, constant worry, fear and constant family conflicts, due to living with a member with PTSD.

Observable draw backs on families in terms of major domestic and household developments and general family life future planning were also reported as part of the experienced family problems. The above finding is in line with findings by Iniedu (2011:3), who assessed the impact of the veterans' PTSD symptoms upon the wives, marriage and family lives among wives of Iraq and Afghanistan war veterans, and reported withdrawal and avoiding of other people, social interactions, crowds and gatherings as one of negative effects of PTSD on social relations.

Furthermore, increased impaired and unsatisfying social relationships, high marital and family violence leading to divorce and more demoralisation, social isolation, feelings of helplessness, anxiety and withdrawal were reported amongst the partners of Vietnam veterans with PTSD compared to partners of Vietnam veterans not diagnosed with PTSD and among families living with a member diagnosed with PTSD in the USA (Price et al 2014:7; Tull 2014:2). In addition, findings in studies by Iniedu (2011:3) and Ray et al (2011:15) documented similar data with regard to family members' experiences of changing emotions due to living with a member diagnosed with PTSD.

Financial problems, largely as a result of having a family member with PTSD, included improper financial management; extensive medical bills and continuous exposure to debts, as indicated by close to a third of the family members. This specific social effect was most common in families separated from one another and working far apart in terms of job placement and in instances where medical funds got depleted. Financial problems brought about major drawbacks, which led to family members feeling stuck in the face of major family and household developments. Similarly, findings by Tull (2013:2) on families of the Vietnam military veterans reported financial strain, such as inadequate funds to cater for high medical bills, household needs and children's educational funds due to financial mismanagement by the PTSD sufferer was experienced.

Findings of the current study showed that lack of constant support from the SAPS organisation to help manage living with a member diagnosed with PTSD was indicated as a major challenge by some of the family members. Studies conducted in the USA, on workers and families living with a member diagnosed with PTSD by Tull (2013:16) and

Reardon (2009:4) highlighted workers' PTSD management guidelines for employers. The studies indicated the importance of providing support in the form of counseling to families to enable them to cope with stress reactions manifesting as a result of the burden of caring for a member living with PTSD (Tull 2013:6; Reardon 2009:4).

Studies conducted on the Metro police workers in the Gauteng Province by Kgalema (2002:16), in the Limpopo Province by Van Lelyveld (2008:14) and Madu et al (2006:216) and in the USA by Lynch (2007:5) noted the direct impact of living with a family member diagnosed with PTSD on families and emphasised the need for adequate support to be given to such families.

According to the current findings, the effects of living with a family member with PTSD impacted largely on the minority of the children and spouse's performance at school and at work. Decreased school and work performance was mainly attributed to poor concentration caused by grave concern for the health and well-being of their parent and spouse. Findings from a study conducted by Tull (2013:1) on families with a member diagnosed with PTSD in the USA, pointed out that problems associated with PTSD such as substance use and unpredictable behavior patterns displayed by the PTSD sufferer may become too distressing for family members who will consequently show stress symptoms including decreased school and work performance, loss of interest and withdrawal. Similarly, findings in studies conducted among police workers and military veterans in the USA by Brown (2012:2), Boaz (2014:16), the National Centre for PTSD (2012:1) and the Department of veterans' affairs (2011:59) observed that police workers' children and spouses get mainly affected by changes in the PTSD sufferer's behavior, in some cases the impact results in behavioral problems among the affected children.

In terms of the WTM, the above findings on the health and social effects of living with a member diagnosed with PTSD point to the component of telling/ retelling the traumatic story and normalising the traumatic symptoms. The two components of the model emphasise the need and importance of catharsis through giving a detailed description of family members' traumatic symptoms and experiences and discussing them into detail, normalising the reactions and educating the families on other symptoms which may ensue (Eagle 1998:139). These components call for awareness and acknowledgement of the traumatic impact brought about by rendering care to a loved one living with PTSD spilling on to family relations. Family members serve as a support structure for the



worker diagnosed with PTSD. Therefore, rendering trauma support through integrated family counseling, empowering families on post-traumatic stress symptoms, their effect and providing information on the normality of experiencing symptoms, such as family conflicts, negative stress and withdrawal symptoms, is vital.

Furthermore, with these two components of the WTM, family members shall be assisted to realise that talking about trauma is a supportive occupational health intervention tool, as they allow for historical trauma memories to be managed. Bringing the traumatic experiences, thoughts and effects to the surface is helpful in modifying irrational and distorted thoughts normally experienced by trauma survivors and their caregivers (Eagle 1998:139). Therefore, these will in turn assist families to manage living with a member diagnosed with PTSD.

#### **6.12 FAMILY MEMBERS' COPING WITH THE EFFECTS OF LIVING WITH A MEMBER DIAGNOSED WITH PTSD**

The use of support from immediate and extended families and friends was reported to have helped over half of the participants to manage the effects of living with a member diagnosed with PTSD. This included talking to each other and learning more about the health condition, sharing household responsibilities and assisting the member with PTSD with the correct taking of medication. Similarly, the use of social support in managing living with a family member with PTSD was documented by the US Department of Veterans Affairs (2014:2), Boaz (2014:15) and Tull (2014:2) in studies conducted among families living with a member diagnosed with PTSD in the USA. The need for family members to learn more about the health condition, the symptoms, treatment and symptom triggers was reported by Tull (2013:4) as vital in the management of PTSD.

The study findings also showed that few of the families coped by trying to be strong and avoiding conversations with the PTSD sufferer (parent/ spouse/ child sibling). On the contrary, Lynch (2007:60) confirmed that the use of the avoidance strategy delays trauma recovery, and is not beneficial in dealing with trauma and PTSD.

Practicing religion, specifically attending church and praying together to establish and maintain family support was also reported by most participants. Findings from studies conducted on families with a member diagnosed with PTSD in the USA noted that the families coped by understanding their loved ones' traumatic symptoms and impact on

behavior. In addition, obtaining professional help as a family and exercising relaxation techniques, such as listening to music, praying and reading, assisted families to cope with PTSD (Tull 2013:4; Ruzek 2012:1).

The study findings on coping with the health and social effects of living with a family member diagnosed with PTSD is closely concomitant with the WTM's component of promoting mastery of traumatic symptoms, which advocates for active implementation of adequate and effective coping strategies among individuals exposed to and directly affected by trauma and PTSD. Mastering traumatic symptoms is aimed at enabling continuation with responsibilities of daily living and the re-establishment of previous levels of coping among families affected by living with a member diagnosed with PTSD (Eagle 1998:142). Education among family members on how to best render care and support to their loved one is fundamental. Generating effective coping mechanisms among families caring and supporting a worker with PTSD is also essential.

In addition, awareness and empowerment on how families can manage their own traumatic responses to the situation is important. Thus, educating them on effective and non-effective coping strategies is crucial in order to support and assist on coping with a member diagnosed with PTSD. The positive health and wellness of family members contributes positively to the wellness of the worker diagnosed with PTSD and ultimately promotes PTSD management and best job performance. Thus, a healthy and well employee is highly likely to do their best at work and contribute positively to the achievement of set organisational objectives.

### **6.13 FAMILY MEMBERS' OPINIONS AND RECOMMENDATIONS FOR THE MANAGEMENT OF LIVING WITH A MEMBER DIAGNOSED WITH PTSD**

Current findings showed that a large proportion of family members viewed the provision of combined family counselling sessions, home and hospital visits as critical for management of the effects of living with a member diagnosed with PTSD. Similarly findings from studies conducted by Tull (2013:20) and Boaz (2014:18) on families with a member diagnosed with PTSD emphasised the importance of taking part in couples counselling and therapy, which enhances communication and counter feelings of isolation, mistrust, loss of control and withdrawal within families in an effort to improve coping with PTSD.

Findings in the present study indicated that a majority of participants viewed the provision of life skills empowerment programmes for all families affected by living with a worker diagnosed with PTSD as fundamental in the management of the effects thereof. Similarly, findings in studies conducted by DeAngelis (2008:44) and Boaz (2014:18) among families living with a member diagnosed with PTSD in the USA documented that teaching families stress management techniques and providing psycho-education about the condition, such as symptoms, course, triggers and its treatment, is essential. In addition, education on effective communication, problem solving and anger management skills to the families is a critical strategy that mental health practitioners can use to help PTSD clients and their families deal with the effects of PTSD (DeAngelis 2008:44; Boaz 2014:18) . Further findings among families living with a member diagnosed with PTSD in the USA, conducted by Tull (2013:1), emphasised learning about the symptoms of PTSD and understanding their influence on behaviour as the first step toward living with and helping a loved one with PTSD.

In the same breath, transferring workers diagnosed with PTSD nearer to families was also reported by a few of the families as an essential strategy to assist in managing the effects thereof. Findings from Tull's (2012:24) studies on families with a member diagnosed with PTSD pointed that the family is the most critical support system and further reported the importance of rendering constant and immediate family support to the member diagnosed with PTSD. Being there, understanding PTSD symptoms and triggers of the symptoms, and changing routines based on the member's symptoms requires family members to always be available. Thus, transferring workers nearer to families will enable the provision of necessary immediate family support for workers with PTSD.

In the current study, a minority of family members pointed out the need for workers with PTSD to be provided with adequate medical assistance as well as the extension of study bursaries to all families living with a member diagnosed with PTSD. Findings in a study conducted in the USA by Reardon (2009:3), which examined how organisations can render support to combat veterans diagnosed with PTSD, emphasised the importance of employers making an assessment of how best to adjust and accommodate these workers and their families, further highlighting that rendering simple and inexpensive workplace and family support can assist such workers and families to achieve life fulfilment and recovery from the health condition. Such support

can also contribute positively towards the attainment of organisational goals and objectives (Reardon 2009:3).

In the WTM, the above findings on family members' opinions and recommendations for PTSD management relates to the two components of the model: promotion of mastery of traumatic symptoms and facilitating the creation of meaning. These components promote the establishment and maintenance of the use of a variety of support systems, including family and friends, the organisation, psycho-education on experienced stress and trauma reactions (Eagle 1998:142). In addition, the emphasis and focus is on the trauma survivor's belief system in creating hope and meaning, at the same time being aware of the impact of trauma and PTSD in his life. The latter is important to unleash the capability to lead a manageable and positive life (Eagle 1998:143). Through integrated family trauma counseling, using the WTM, family members will be using and benefiting from the support rendered by the SAPS organisation to help manage the effect of living with a worker diagnosed with PTSD. The SAPS workers' immediate family members experience direct effects of living with a worker with PTSD, therefore, taking their recommendations into consideration will bring about a sense of being cared for and supported by the SAPS organisation. The support will also serve as a positive reinforcement to continue caring and sustaining their loved ones living with PTSD. Therefore, feelings of self-confidence, belongingness and attainment of greater optimism are highly likely to ensue among the SAPS workers' family members.

#### **6.14 CONCLUSION**

This chapter provided a detailed discussion of the findings on work and non-work-related traumatic incidents leading to a possible PTSD development. Information on how PTSD and living with a family member diagnosed with PTSD impacted on the health and social being of the SAPS workers and their immediate family members was also documented. Available occupational health and wellness support programmes as well as coping mechanisms used by participants and family members were also pointed out in this chapter.

The next chapter presents the contributions, conclusions and limitations of the current study. Recommendations developed on the basis of the findings of the current study are also presented in the next chapter.

## **CHAPTER 7**

### **SUMMARY, CONCLUSIONS, RECOMMENDATIONS, CONTRIBUTIONS AND LIMITATIONS OF THE STUDY**

#### **7.1 INTRODUCTION**

This chapter presents the summary of the study with the major findings. The conclusions drawn from the main research findings and the contributions of the current study are also discussed. The recommendations gathered from the key findings of the study and its limitations are also presented in this chapter.

#### **7.2 SUMMARY OF THE STUDY FINDINGS**

##### **7.2.1 Local PTSD prevalence rate**

The study found a lower prevalence rate of 0.76% in the Mahikeng area.

##### **7.2.2 Traumatic incidents leading to a possible PTSD development**

It was found in this study that most participants were exposed to gruesome traumatic incidents, which were mainly work-related and could lead to possible PTSD development.

##### **7.2.3 Health and social effects of PTSD on participants**

The findings suggested that exposure to the incidents may have had a considerable effect on the participants' health and social lives as most of them often lost appetite, suffered from persistent fatigue, felt depressed and found it difficult to fall asleep. Socially, most of them pulled away from their friends and societal systems. These effects were linked to constant exposure to traumatic incidents.

##### **7.2.4 Participants' coping mechanisms to deal with PTSD**

Most participants received support from their loved ones and friends and as a result gathered strength to deal with the health and social effects of PTSD.

### **7.2.5 Available on-site occupational health interventions for the management of PTSD**

A variety of health and wellness programmes are available at the study site to assist workers manage the effects of PTSD. However, the programmes are not adequately implemented to meet the needs of all workers diagnosed with PTSD and their immediate family members. This was mainly attributed to inadequate EHW personnel who would render the services at the study site.

### **7.2.6 Participants' opinions and recommendations for PTSD management**

Most participants felt that receiving support from the employer in the form of adequate provision of psycho-social and spiritual counseling services and active participation in PTSD support groups and sport activities were fundamental to PTSD management.

### **7.2.7 Health and social effects of PTSD on family members**

Living with a family member diagnosed with PTSD had major effects on the health and social being of all family members. Most family members considered the situation and experiences as traumatic. Furthermore, the often experienced family-related challenges and negative stress was linked to responsibilities involved in taking care and living with a member diagnosed with PTSD, which triggered constant worry about the wellbeing of the working family member with PTSD. In addition, most of them experienced financial problems.

### **7.2.8 Family members' coping mechanisms to deal with PTSD**

Most families coped with living with a member diagnosed with PTSD by supporting each other during times of need and praying together.

### **7.2.9 Family members' opinions and recommendations for PTSD management**

The findings revealed that an overwhelming majority of family members were of the view that if the SAPS organisation could provide them with continued support through home visits to provide joint psycho-social and spiritual family counseling services, and educate them on necessary life skills intended at empowering them, they would be in a better condition to manage living with a working member diagnosed with PTSD.

### **7.3 CONCLUSIONS**

Although a lower prevalence rate of PTSD was established in the findings of this study, there is need for a robust implementation of trauma and PTSD support and management programmes at the study site. This implementation of support and management programmes will curb the development into high prevalent levels.

The study identified a wide range of the social and health effects of PTSD on the SAPS workers and their immediate family members. Furthermore, some gaps with regard to available occupational health and wellness programmes were identified. These gaps pointed to the fact that the working environment for workers diagnosed with PTSD is dominated by inadequate support and labeling by top management, the immediate commander and fellow colleagues. In addition, inadequate SAPS EHWP services, due to a shortage of personnel within this specific unit, serve as a stumbling block towards PTSD management for both the workers and immediate family members. As a result, the much required health and wellness services cannot be sufficiently extended to families.

### **7.4 RECOMMENDATIONS**

The following recommendations are made on the basis of the findings of this study and the conclusions drawn from the findings:

#### **7.4.1 Workplace support programmes**

- PTSD information and awareness sessions should be presented by the EHW personnel to educate immediate family members, who live with, and are taking care or rendering necessary support to the member diagnosed with PTSD. Furthermore, commanders and fellow police workers who are also work support structures and constantly interacting with workers diagnosed with PTSD in the work environment should be empowered about the health condition and how it affects individuals. This will create an understanding regarding PTSD, enhance support at home and at work, and minimise discrimination and acts of labeling among workers with PTSD, especially in the work environment. This should be conducted in conjunction with stakeholders such as external mental and health professionals and experts, including specialist psychiatrists and counseling, educational and clinical psychologists.

- Efforts to manage PTSD should be carried out by the EHW, the SAPS management and health and mental professionals to share identified factual data on the contributing factors to mental health conditions within the SAPS Mahikeng cluster. Collaboration between these sectors will assist in the identification of ways to manage the situation.
- There should be presentation of life skills programmes by the SAPS EHW personnel, including financial management to all SAPS workers diagnosed with PTSD and to their immediate families to empower them with effective coping skills.
- The EHW personnel should inform all workers about their services, including the benefits of actively participating in the EHW programs.
- Commanders and fellow police workers should support and not label workers diagnosed with PTSD as the “crazy ones”.
- The Mahikeng area management should support the EHW personnel, who in conjunction with sport coordinators should ensure the establishment, co-ordination and refurbishment as well as maintenance of the gymnasium at the Mahikeng cluster offices. The development and up keeping of varying sporting activities, recreational and indigenous games in the Mahikeng cluster area to promote, team spirit and healthy and active lifestyles is indeed fundamental to PTSD management.
- Development, maintenance and facilitation of PTSD support groups within the Mahikeng cluster, by the EHW personnel, will enable workers to have immediate access to this crucial service meant to promote group cohesion and belonging, aspects fundamental to PTSD management. This service does not exist at the study site.

#### **7.4.2 Accommodative policies**

- Support by employer in the form of inclusion within the health and wellness policies for alternative and suitable placement of workers to release workers diagnosed with PTSD from operational duties to accommodative administrative duties, is needed.



- The SAPS organisation's transfer policy should be adapted to accommodate workers diagnosed with PTSD to ensure that they are transferred to places that are close to their immediate family members for necessary support. The policy should grant approval for workers' medical boarding applications due to PTSD ill health.
- The POLMED Psychiatric disease and treatment management and support programme should render awareness about this service and encourage workers with PTSD to register for the service. Adequate and available medical aid funding should be provided by the employer and be accessible to all workers diagnosed with work-related PTSD as well as to their immediate family members.
- Institutionalise a policy to provide financial support in the form of tertiary bursaries specifically for the immediate family members of the SAPS workers diagnosed with work-related PTSD.

#### **7.4.3 Family support programmes**

- There should be provision of integrated EHWP counseling, debriefing as well as adequate care and support services in the form of telephonic support, hospital and home visits to all workers' immediate family members to help them cope effectively with the health and social effects of living with a member diagnosed with PTSD, particularly during ill health episodes.
- The EHW personnel should conduct adequate follow up sessions with all families affected by living with a member diagnosed with PTSD to assess their coping levels and to continue rendering necessary psycho-social and spiritual support.

#### **7.4.4 Enhanced access to the SAPS EHWP services**

##### **7.4.4.1 Capacitation of the SAPS EHW Programme**

- Ensuring that adequate services are rendered by the EHW Programme in the Mahikeng area should be done by the SAPS Mahikeng and Northwest Provincial EHW management to enable accelerated and readily available access to psychological, social and spiritual support services for all workers diagnosed with PTSD and their immediate family members, most essentially enhanced provision to trauma debriefing, PTSD support group and counseling services salient in PTSD management.

- The SAPS organisation should train all trauma debriefers using the Wits Trauma Model (WTM) to equip them with more skills as presented in the model to help with workers' and families' PTSD management.
- Adoption of the WTM by the SAPS management and EHW management forums at Mahikeng area, the SAPS North-west provincial headquarters in Potchefstroom and the SAPS Head office in Pretoria, is fundamental to PTSD management in the Mahikeng area.
- The adaption of the WTM training programme by the WTM trainers and facilitators to suit the SAPS environment during training of the EHW practitioners is essential in order to ensure its relevancy and effectiveness to the unique SAPS work environment which is constantly exposing workers to trauma.
- Effective implementation of the WTM within the SAPS organisation by the EHW personnel after obtaining training on the model is crucial to PTSD management.
- The EHW personnel should facilitate the training and re-training of commanders on initial debriefing (defusing) to render immediate support to traumatised workers and to refer them for formal debriefing as a means of preventing PTSD development
- The SAPS provincial and Mahikeng cluster management should develop and maintain a retention strategy for EHW Professionals in the Mahikeng area. This will ensure uninterrupted and sufficient counseling as well as other health and wellness support services for the SAPS workers with PTSD and their immediate family members.

## **7.5 CONTRIBUTIONS OF THE STUDY**

The study's contribution is noted in its substantial input to the existing body of knowledge in the field of trauma studies. The study collected and analysed a great amount of data relating to health and the social effects of PTSD, data related to work and non-work-related traumatic incidents leading to the possible development of PTSD and relevant coping strategies for PTSD management. Furthermore, the inclusion of family members in the study brought about crucial data which pointed to the fact that adequate support from the SAPS organisation is essentially required for families to manage living with members diagnosed with PTSD.

It is envisaged that the developed guidelines will serve as a framework for the promotion of employee care and support within the SAPS organisation in the Mahikeng area. The guidelines are also envisaged to guide policy makers within the SAPS organisation occupational health and wellness policies that are accommodative and inclusive for workers diagnosed with PTSD. Furthermore, the study comes at a critical time when there is constant questioning as well as feedback and accountability reports required by the general public and the Parliament from the National police Commissioner and Minister on programmes in place to ensure the psychological health and wellness of the SAPS workers; given the traumatising nature of their work.

## **7.6 LIMITATIONS OF THE STUDY**

Limitations were inevitable due to the sensitive and intricate nature of the researched area. This was evident in the limited number of participants who consented to partake in the study and on the few who acceded for their immediate family members to participate in the study.

Potential information recall bias could not be ruled out in the responses provided by the participants. This was observed among participants' responses to some of the questionnaire items. Participants became emotional and would keep quiet for some time before responding. It was understood that they were uncomfortable to respond to some of the items. In addition, the findings of the study may not be generalised to other police workers and police environments as the study only focused in one area, and included a limited study population.

## **7.7 CONCLUSION**

This chapter presented a summary of the key findings of the current study. Conclusions and recommendations drawn from the key findings were also presented in this chapter. The next chapter will present the guidelines developed as a reference point for the management of PTSD in the SAPS organisation of the Mahikeng area and among the workers' immediate family members.

## CHAPTER 8

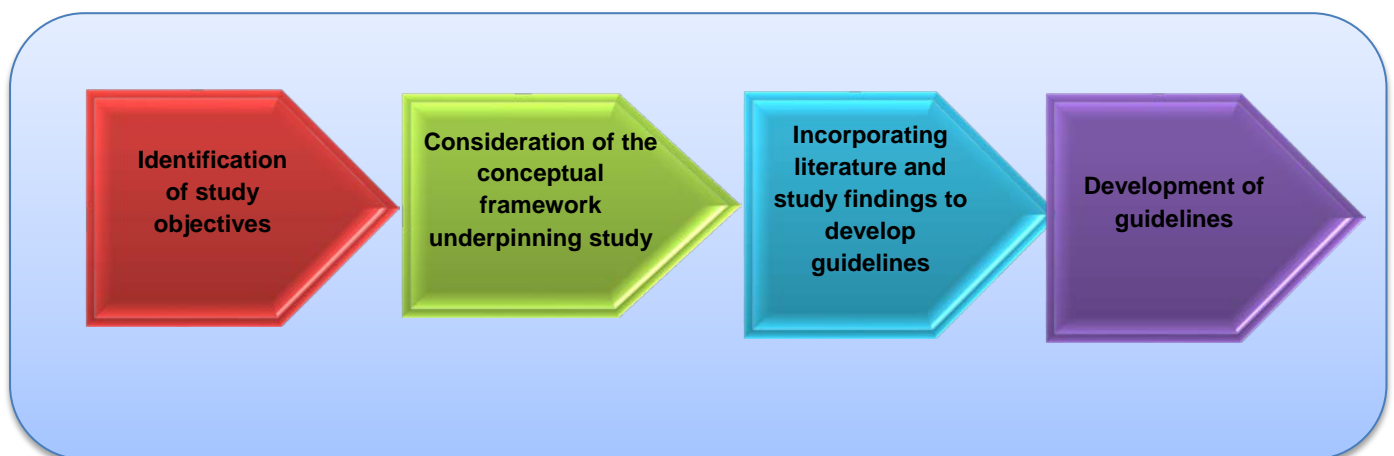
# GUIDELINES FOR MANAGEMENT OF POST TRAUMATIC STRESS DISORDER (PTSD) AMONG THE SOUTH AFRICAN POLICE SERVICE (SAPS) WORKERS IN MAHIKENG, NORTH WEST PROVINCE OF SOUTH AFRICA

### 8.1 INTRODUCTION

This chapter presents the guidelines for the management of PTSD among the SAPS workers in Mahikeng. The chapter further explains the processes followed in developing the guidelines. The guidelines were developed as the primary purpose of the current study in order to address the problem statement described in chapter one of this thesis.

### 8.2 PROCESS OF DEVELOPING THE GUIDELINES

The guidelines were developed by aligning the key findings of the study with the literature review and the theoretical framework. Therefore, the relevant aspects of literature reviewed on the health and social effects and management of PTSD, as discussed in chapter 2 of this report and the relevant components of the WTM, as discussed in chapter 3 of this report, were linked to the main study findings as discussed in chapter 6 of this report, to guide the development of the guidelines for the management of PTSD among the SAPS workers in the Mahikeng area. Figure 8.1 below illustrates the different steps that were followed in the development of the guidelines.



**Figure 8.1 Schematic presentation of the process of guideline development**  
(Chaponda 2011:145)

### **8.3 APPLICATION OF THE WITS TRAUMA MODEL TO THE DEVELOPMENT OF THE GUIDELINES**

The central base of the WTM is that trauma impacts on both the internal and external psychological functioning of individuals as well as the notion that psychodynamic and cognitive-behavioral processes interact to influence the development, maintenance and prevention of PTSD (Bean 2008:13; Hajjiannis et al 1999:4). Therefore, to effectively manage the effects of trauma on individuals, an implementation of an integrated approach which is structured and problem-oriented in addressing cognitive-behavioral processes is immensely obligatory (Eagle 1998:138).

In Table 8.1, the main areas arising from the study findings concerning the health and social effects of PTSD on the SAPS workers are presented with relevant components of the WTM. Table 8.2 presents information obtained from family members concerning the effects of living with a member diagnosed with PTSD with applicable components of the WTM. Recommended activities for the adoption and implementation of each guideline are presented in both tables. The crux of the process of guideline development is essentially to ascertain that the SAPS organisation renders the required support to workers diagnosed with PTSD and their immediate family members for its management.

**Table 8.1 Tabular presentation of guidelines for the management of PTSD among the SAPS workers in Mahikeng, North West Province of South Africa (The SAPS workers' study findings)**

Study objective	Findings from the study	Relevant Component/s of the Wits Trauma Model	Recommended activities for adoption and implementation of the guidelines
<p><b>1 Traumatic incidents leading to a possible PTSD development.</b></p> <p>1.1 Participants' experiences of work-related traumatic incidents for possible PTSD development.</p> <p>1.2 Participants' experiences of non-work-related traumatic incidents for possible PTSD development.</p>	<p>1 Constant exposure to work-related incidents of shooting, rape and gruesome murder scenes, community and colleague suicides and prisoner escapes from lawful custody.</p> <p>1 Exposure to death of significant others, abusive marriage and suicide of a participant's child.</p>	<p>1 Telling/retelling the traumatic story, and addressing survivor guilt.</p>	<p>1 The SAPS EHW management should ensure that the SAPS Mahikeng trauma debriefers are trained in the WTM to help workers diagnosed with PTSD with the process of anticipating trauma and traumatic symptoms and in dealing with the reality of being constantly traumatised and having to live with regular triggers of previous trauma given the traumatic nature of policing work.</p> <p>1 Through skills acquired from the WTM training, the EHW personnel will be more equipped with advanced trauma counseling and therapeutic skills relevant to the South African context. Through training, the EHW personnel will be able to integrate cognitive-behavioral approaches in managing trauma and PTSD as well as promote psychological wellness and healing among workers and their immediate family members.</p> <p>2 EHW personnel should robustly raise awareness and encourage workers to also receive professional assistance to enable ventilation</p>

Study objective	Findings from the study	Relevant Component/s of the Wits Trauma Model	Recommended activities for adoption and implementation of the guidelines
			<p>about challenges emanating from personal, family, social and marital lives in order to avoid experienced problems developing into more complex health and psychological conditions.</p> <p>3 Upon receiving the WTM training, the EHW personnel should effectively implement the model to ensure PTSD management.</p>
<p>2 <b>Effects of PTSD among participants.</b></p> <p>2.1 Health effects of PTSD among participants.</p>	<p>1 Experiences of emotional, behavioural and mental effects including anger, insomnia, irritability, fear, suspicion and lack of trust.</p>	<p>1 Normalising the traumatic symptoms.</p>	<p>1 The EHW personnel should conduct regular information sessions to empower employees on health related aspects such as Stress management, Depression, and other general and chronic health conditions. They must also encourage and arrange for workers to take part in regular health checkups for conditions such as Blood sugar diabetes, Blood pressure, cancer, HIV/AIDS and Cholesterol as developmental and co-existing health conditions due to PTSD for a pro-active management of health related problems.</p> <p>2 The EHW personnel should provide psycho-education and information sessions to empower workers and immediate family members on life skills, different sources of stress, the effects of stress and trauma, and symptoms of PTSD as well as how to effectively manage them.</p> <p>3 The EHW personnel/ trauma debriefers should constantly reassure workers that their responses are normal reactions to abnormal situations and that they will diminish with support and educational coping mechanism given and implemented by the workers.</p> <p>4 Through skills acquired from the WTM training, EHW debriefers should</p>

Study objective	Findings from the study	Relevant Component/s of the Wits Trauma Model	Recommended activities for adoption and implementation of the guidelines
2.2 Social effects of PTSD among participants.	<p>2 Perceived lack of support from friends and colleagues during time of sickness due to PTSD.</p> <p>1 Loss of interest in friendships, cutting social ties and withdrawal from social networks.</p>		<p>equip workers with the necessary skills to employ when they are directly faced with stimuli related to the trauma rather than avoiding it.</p> <p>5 EHW trauma debriefers should use relevant skills acquired during the WTM training to offer trauma therapy and help reduce the trauma-induced fear and the chances of workers suffering secondary traumatisation due to the fear of their traumatic symptom.</p> <p>1 The EHW personnel should encourage and enhance commander and co-worker care and support during times of ill health due to PTSD.</p> <p>1 Through counseling and therapy, the EHW personnel should encourage and take workers through the process of re-establishment and maintenance of social relationships and talk to families and friends, and practice hobbies as well as partake in extramural activities.</p>
3 Participants' coping mechanisms to deal with PTSD.	<p>1 Use of support from family and friends.</p> <p>2 Practicing hobbies.</p> <p>3 Practicing religion.</p> <p>4 Utilisation of guidelines</p>	1 Promoting mastery of traumatic symptoms	<p>1 The EHW personnel should encourage the maintenance of supportive friendship and immediate family relations as well as extended family networks.</p> <p>2 The EHW personnel should encourage regular engagement in hobbies for physical and mental wellness and continued coping with PTSD.</p>



Study objective	Findings from the study	Relevant Component/s of the Wits Trauma Model	Recommended activities for adoption and implementation of the guidelines
	<p>acquired form counseling sessions.</p> <p>5 Utilisation of sleeping as an avoidance mechanism.</p> <p>6 Use of alcohol to cope with PTSD.</p> <p>7 Use of perseverance as a coping mechanism.</p>		<p>3 The EHW personnel should encourage practicing religion, i.e. active utilisation of the internal SAPS spiritual services and use of external religious support for empowerment and life skills education to promote coping with PTSD.</p>
<p>4 <b>Available onsite occupational health interventions for management of workers with PTSD.</b></p>	<p>Inadequate implementation of the following programs due to insufficient funding and EHW personnel at the study site:</p> <p>1 Psycho-social and spiritual counselling.</p> <p>2 Initial debriefing/ defusing.</p> <p>3 Formal debriefing.</p>	<p>1 Promoting mastery of traumatic symptoms.</p>	<p>1 The SAPS organisation management should ensure retention of the EHW personnel in the Mahikeng area so that they will have adequate professionals who will implement the occupational health and wellness programs.</p> <p>1 The EHW personnel should provide adequate psycho-social and spiritual counselling services to all workers diagnosed with PTSD in the Mahikeng area.</p> <p>1 The SAPS and the EHW management should ensure all initial debriefers'/defuser's commitment and active involvement in rendering initial debriefing (defusing) services by including the responsibility of initial trauma debriefing as part of Key Performance Area (KPA) to report to higher organisational authority.</p> <p>1 The SAPS management should ensure adequate formal debriefers in</p>

Study objective	Findings from the study	Relevant Component/s of the Wits Trauma Model	Recommended activities for adoption and implementation of the guidelines
	<p>4 PTSD support group.</p> <p>5 Multiple Stressor Debriefing (MSD) programme.</p>		<p>the Mahikeng area to offer debriefing services to all affected workers.</p> <p>2 The formal debriefers should encourage initial debriefers to refer all workers for formal debriefing to ensure effective trauma management and curb the development of new PTSD cases. 1. With the implementation of the WTM within the SAPS organisation, the EHW personnel should develop and maintain PTSD support groups for workers to encourage solidarity and assist in managing the effects of PTSD.</p> <p>1 The EHW personnel should extend development, facilitation and the maintenance of PTSD support group services to the workers' immediate family members to assist families manage living with a member diagnosed with PTSD.</p> <p>1 The SAPS management should ensure that there are adequate EHW professionals that are specifically trained to carry out quarterly high risk unit psychological sessions (multiple stressor debriefing) to enable effective coping with constant exposure to trauma within these specific units.</p> <p>2 The EHW management should ensure adequate funds allocated and readily available for the implementation of various EHW Programs such as life skills, multiple stressor debriefing and other capacity building programs to enhance coping through presentation and facilitation of such programs at police stations and units. Programs on team building and maintenance, diversity management, Men and Women's health promotion work place programs and financial management to be</p>

Study objective	Findings from the study	Relevant Component/s of the Wits Trauma Model	Recommended activities for adoption and implementation of the guidelines
	<p>6 The POLMED Psychiatric disease management programme.</p>		<p>focused on too.</p> <ol style="list-style-type: none"> <li>1 The EHW personnel in conjunction with the POLMED Psychiatric disease and treatment management and support program personnel should encourage the SAPS workers diagnosed with PTSD to register with the medical aid scheme for assistance in financial management of health fees and costs.</li> <li>2 The POLMED office personnel should encourage all workers diagnosed with PTSD to register on the POLMED chronic and Psychiatric Disease and Risk Management Program and make the support services available and accessible to all workers and families affected by PTSD in the Mahikeng area.</li> <li>3 The POLMED office personnel should provide adequate medical funds for workers with PTSD, to avoid funds being exhausted.</li> <li>4 Request external health professionals such as specialist psychiatrists and clinical psychologists to share available factual statistical information on aggravating work-related factors giving rise to PTSD within the SAPS organisation: Mahikeng area. And to collectively work out a comprehensive and effective strategy to suit the needs of both the health professionals, the workers diagnosed with PTSD and the SAPS organisation as an employer.</li> </ol>

Study objective	Findings from the study	Relevant Component/s of the Wits Trauma Model	Recommended activities for adoption and implementation of the guidelines
<p>5 <b>Participants' opinions and recommendations for PTSD management.</b></p>	<p>1 The need for the provision of adequate care and support through the following</p> <p>1.1 Provision of integrated family counselling and support services.</p> <p>1.2 Provision of adequate hospital and home visits to all workers affected by PTSD in the Mahikeng area</p> <p>1.3 The need for the provision of alternative job placement for workers diagnosed with PTSD.</p> <p>1.4 The need for reduced workload.</p>	<p>1 Promoting mastery of traumatic symptoms and facilitation of creation of meaning.</p>	<p>1 The EHW personnel should render adequate psychosocial and spiritual counselling to both the SAPS workers diagnosed with PTSD and their immediate family members.</p> <p>2 The SAPS National Head office and Provincial medical administration Employee Relations and Life Cycle Management and Occupational Incidents personnel should conduct regular visits at SAPS workers diagnosed with PTSD's homes and work stations and units to assess their work conditions and wellbeing.</p> <p>1 Commanders, the EHW personnel and co-workers should render adequate support in the form of visits at home and hospitals and telephonically check on how the workers diagnosed with PTSD are doing, especially when they are away from work due to ill health.</p> <p>2 The SAPS management should ensure adequate EHW personnel capacity to carry out constant home, hospital visits, and telephonic support sessions and follow up on wellbeing for all SAPS workers.</p> <p>1 The SAPS management should accommodate workers diagnosed with PTSD in alternative job placement, such as placing them to work straight shifts, to avoid interruption with PTSD medical treatment which must be consumed at night. The effects experienced from the medication normally limits coping with the demands of night shift and operational work.</p> <p>2 The SAPS management should consider the medical reports on mental and health status and capability of the employee diagnosed with PTSD, and alternative job placements for workers diagnosed with PTSD should be done to accommodate their mental and physical ability. For</p>

Study objective	Findings from the study	Relevant Component/s of the Wits Trauma Model	Recommended activities for adoption and implementation of the guidelines
			<p>example the nature of work should be less demanding/ less stressful to suit the needs of the workers diagnosed with PTSD.</p> <p>3 The SAPS management should create an environment conducive for working, but not pampering for workers diagnosed with PTSD by being aware of PTSD, symptoms and symptom triggers and the effects it has on the workers lives. They must also assign less demanding job and decrease work load to enable management with the effects of PTSD.</p> <p>4 Commanders should appreciate the contribution made by workers diagnosed with PTSD in the work environment. Commanders should encourage workers to actively participate in various policing tasks which they are passionate about and are able to cope with, given the effect of the health condition on their work performance. This will enable workers diagnosed with PTSD to rebuild and maintain a sense of self-esteem, confidence, self-concept, optimism, assertiveness, and self-efficacy and regain control over their lives.</p> <p>5 The SAPS management should place workers diagnosed with PTSD in work stations that will not re-traumatise them, for instance assign them to conduct pure administrative and support duties.</p>

Study objective	Findings from the study	Relevant Component/s of the Wits Trauma Model	Recommended activities for adoption and implementation of the guidelines
	1.5 Provision of information sessions about PTSD to colleagues in order to curb labelling and discrimination.		<ol style="list-style-type: none"> <li>1 The EHW personnel should invite external health professionals, including specialist psychiatrists and clinical psychologists, to render information sessions on health conditions such as Depression, PTSD and other psychotic disorders. The sessions should be offered to the immediate family members, the SAPS management and co-workers, to establish an increased understanding of how these health conditions affect workers' family, social, work relations and performance.</li> <li>2 Commanders and co-workers should not label workers diagnosed with PTSD as the "sick ones". They should give them fair and equal treatment that is accompanied by respect.</li> <li>3 The EHW personnel should encourage co-workers and management to listen, empathise, and be patient and non-judgmental to help reduce feelings of guilt or self-blame.</li> <li>4 The EHW personnel should encourage commanders and co-workers to develop an attitude and a sense of caring for employees, especially the ones experiencing ill health, and not perceive them as "problematic employees" but rather render the necessary support during ill health. Develop a humane, non-judgmental and <i>Ubuntu</i> attitude and culture within the SAPS organisation which does not looking down at, alienate or downgrade workers diagnosed with PTSD.</li> </ol>

Study objective	Findings from the study	Relevant Component/s of the Wits Trauma Model	Recommended activities for adoption and implementation of the guidelines
	<p>1.6 The need for job transfers nearer to families.</p> <p>1.7 The need for establishment and maintenance of PTSD support group in the Mahikeng cluster.</p> <p>1.8 The need for active participation in occupational sporting activities.</p>		<p>1 Reasonable provision should be made by the SAPS management not to place workers diagnosed with PTSD away from support systems such as families.</p> <p>1 The EHW personnel should establish and maintain support groups for workers and families diagnosed and affected by PTSD in the Mahikeng area, so that they share common experiences and effectively manage their challenges.</p> <p>1 The EHW personnel should introduce various sporting activities at all work stations and remote police stations in the Mahikeng area and encourage all workers diagnosed with PTSD to often utilise the allocated SAPS sport Wednesday period by actively participating in sport of interest.</p> <p>2 The SAPS management and EHW management should ensure a full upgrading of equipment, access control and health and safety use measures at the gymnasium in the Mahikeng area police stations and</p>

Study objective	Findings from the study	Relevant Component/s of the Wits Trauma Model	Recommended activities for adoption and implementation of the guidelines
	<p>1.9 The need for marketing of EHW services.</p> <p>1.10 The need to be offered recognition for special contribution made to the Police organisation.</p>		<p>3. The SAPS management should support health and wellness activities by allocating adequate funds for sports to cater for equipment and gear in the Mahikeng area, to enhance mental and physical wellness.</p> <p>1 The EHW personnel should ensure that all SAPS workers are informed and aware of the EHW services that are readily available. The EHW personnel must conduct robust marketing sessions and promote employee health and wellness services at all police stations and units within the Mahikeng cluster to enhance maximum awareness and usage of such services.</p> <p>1 Through skills acquired from the WTM training, the EHW personnel should assist family members to understand themselves as survivors rather than victims of trauma, and to live with an altered view of themselves and the world in a way that may enhance their future orientation. This may be achieved by offering recognition through job promotion and bravery awards for workers who acquired PTSD in the workplace.</p>



**Table 8.2 Tabular presentation of guidelines for the management of living with a family member diagnosed with PTSD (Family members' study findings)**

Study objective	Findings from the study	Relevant component/s of the Wits Trauma Model	Recommended activities for adoption and implementation of the guidelines
<p><b>6 The effects of living with a family member diagnosed with PTSD.</b></p> <p>6.1 Health effects of living with a family member diagnosed with PTSD.</p> <p>6.2 The social effects of living with a family member diagnosed with PTSD.</p>	<p>1 Major negative effect, Including psychological, emotional, and the development of new health conditions and illnesses such as hypertension, pregnancy miscarriages, rise in blood sugar level, forgetfulness and depression due to stress brought up by PTSD within families.</p> <p>1 Family problems such as marital conflicts and financial problems leading to major drawbacks on family household development processes.</p> <p>2 Friendship problems</p>	<p>1 Telling/retelling the traumatic story and normalizing traumatic symptoms.</p>	<p>1 The EHW personnel should conduct regular family home visits to offer family counseling (combined or individual), trauma debriefing and general support sessions to allow for catharsis of the negative thoughts and painful emotions associated with living with a family member diagnosed with PTSD.</p> <p>2 The EHW personnel should conduct regular telephone support sessions and checkups for all family members affected by living with a member diagnosed with PTSD.</p> <p>3 The EHW personnel should encourage all family members to be registered on medical aid schemes to cater for professional medical and external counseling /therapy fees.</p> <p>4 The EHW personnel should encourage families to go for regular health screening for early detection and management of detected health conditions.</p> <p>5 Trauma debriefers should be available for all the affected family members, and ensure active listening, empathetic reflection as well as use appropriate questioning skills as powerful sources of protection and anxiety reduction.</p> <p>1 The newly acquired skills from the WTM training and their adoption and implementation within the SAPS organisation will empower trauma debriefers and counselors to make links between the traumatic event and the symptoms experienced, as well as reassure them of the normalcy of experiencing such symptoms and prepare them to anticipate/ expect even more reactions.</p> <p>2 The EHW personnel should provide adequate support that reassures family members that their responses are normal reactions to abnormal situations and make them aware that there would be effective management of the traumatic reactions.</p> <p>3 Through family counseling, the EHW personnel should help reduce the chances of families suffering secondary traumatisation because of the fear of their symptoms.</p>

Study objective	Findings from the study	Relevant component/s of the Wits Trauma Model	Recommended activities for adoption and implementation of the guidelines
	<p>including detached families, withdrawal from friends and avoidance of social gatherings and feelings of sadness, frustration as well as constant worry was experienced.</p> <p>3 Lack of constant support from the SAPS organization.</p> <p>4 Decreased job and school performance.</p>		<p>4 Family counseling and therapy sessions should be offered to all affected families to address social, marital and financial, psychological/ emotional problems experienced by most families to enhance coping with the situation.</p> <p>5 The SAPS organisation should provide necessary support to all affected families to assist them with coping with the effects of living with a member diagnosed with PTSD in family, school and work settings.</p>
7 Family members' coping with the effects of living with a member diagnosed with PTSD.	<p>1 The use of support received from extended family members and friends.</p> <p>2 Talking to each other as families.</p> <p>3 Practicing religion and praying together as a family.</p> <p>4 Trying to be strong and avoiding conversations</p>	1 Promoting mastery of traumatic symptoms.	<p>1 The EHW personnel should inform family members of EHW services that are readily available. Provide all family members with EHW contact details including the 24 hour standby and emergency number for easy access to such services. Encourage family members to take the initiative in contacting EHW whenever there is a need for support and counseling to enhance coping measures for family members especially at school and at work. The establishment of rapport among families and EHW should enhance easy access and usage of EHW services.</p> <p>2 The EHW personnel must establish family interactive support groups that meet at least on a quarterly basis and incorporate life skills and empowerment presentations; including loss and bereavement, trauma and other health and wellness information sharing.</p> <p>3 The EHW personnel should encourage and mobilize strong and effective family ties, including the establishment of extended family support network. They must assist family members to acknowledge the existence of PTSD within</p>

Study objective	Findings from the study	Relevant component/s of the Wits Trauma Model	Recommended activities for adoption and implementation of the guidelines
	with the member diagnosed with PTSD as a coping strategy.		families. 4 Through the WTM training, the SAPS therapists and trauma debriefers should use coping skills such as relaxation, stress and anxiety management skills; cognitive techniques such as thought stopping, distraction, time structuring, systematic and desensitization; as some of the stress and anxiety management skills to address concentration and avoidance problems by some family members. Use acquired skills such as cognitive-behavioral principles to restore family members' coping capacities and to assist with both anxiety reduction and management.
8 Family members' opinions and recommendations for effective PTSD management.	<p>1 The need for combined family counselling sessions and home and hospital visits.</p> <p>2 The need for life skills empowerment programs for immediate family members.</p>	1 Promoting mastery of traumatic symptoms and facilitation of creation of meaning.	<p>1 The EHW personnel should offer adequate support to all affected families through home visits and counselling and inform them about available internal resources e.g. EHW, HRM and the SAPS management.</p> <p>1 The EHW personnel should conduct workshops and information sessions on financial management for all families for a pro-active approach in this regard. Offer debt counseling for families in need of such services.</p> <p>2 The EHW personnel should provide information on available external professional services.</p> <p>3 The EHW personnel should equip family members with effective coping strategies to assist in managing the effects of living with a family member diagnosed with PTSD. I.e. Encourage families to spend quality time together to enhance positive relations, understanding and know each other rather than avoiding talking to the PTSD sufferer.</p> <p>4 The EHW personnel should encourage family members to be actively engaged and help with daily routine duties, such as obtaining prescribed medication, and groceries, for family members diagnosed with PTSD.</p> <p>5 The EHW personnel should establish and reinforce effective communication within families, especially between parents and children.</p> <p>6 The EHW personnel should arrange regular health and wellness events in which SAPS family members are invited to be part of to encourage positive and cohesive family relations, and enhance a sense of the mantra <i>"the SAPS my</i></p>

Study objective	Findings from the study	Relevant component/s of the Wits Trauma Model	Recommended activities for adoption and implementation of the guidelines
	<p>3 The need to transfer workers diagnosed with PTSD near families.</p> <p>4 The need to be offered with study bursaries for families of workers diagnosed with PTSD.</p>		<p><i>family”.</i></p> <p>7 The EHW personnel should commemorate national calendar days such as family days by inviting SAPS workers family members to be part of such events.</p> <p>8 The EHW personnel should encourage workers to take part in activities such as a one day <i>“taking a girl/ boy child to work”</i> to empower their own children in terms of the policing environment and enhance family relations.</p> <p>9 The EHW personnel, chaplains should conduct regular spiritual support sessions with all affected families to strengthen their spiritual wellbeing.</p> <p>1 The SAPS management should ensure job placement and transfer of workers diagnosed with PTSD to places close to families as main support structure.</p> <p>1 The SAPS management should develop a trust fund and criteria to extend the SAPS bursary assistance to cater for immediate families, especially SAPS workers’ children affected by parents’ PTSD arising from the execution of official duties, who are in financial need (tertiary education funding) and deserving (tertiary entrance qualification) to help build their better future.</p> <p>2 The debriefers should ensure facilitation of meaning in applicable cases. With the skills acquired from the WTM training, trauma debriefers should identify the needs for the creation of meaning with certain traumatised clients and family members.</p> <p>3 SAPS trauma debriefers will be empowered by the skills acquired from the WTM to acknowledge each individual family member's existing belief system, and through individual trauma counseling sessions, attempt to assist each one to derive some meaning from the traumatic experience. They must also engender some hope and future perspective without denying the damage that the traumatic event would have made on the part of each family member.</p>

## **8.4 RECOMMENDATIONS FOR THE IMPLEMENTATION OF THE GUIDELINES**

### **8.4.1 Preamble**

Effective management of PTSD is complex. A variety of variables such as coping strategies, available resources (internal and external), individual personality characteristics, individual vulnerability, cultural and historical background, ethnicity and upbringing and social and family networks, contribute immensely to how an individual will manage the effects of trauma and PTSD. Other significant variables include the intensity of the trauma and stressors that a sufferer would have been exposed to, response and adherence to prescribed medication, honoring of counseling and support sessions, and the implementation of the coping skills acquired from counseling.

It should be noted that individuals differ on how they can deal with PTSD. However, there are universal and basic coping mechanisms that are presented in trauma literature as applicable and effective in managing the effects of PTSD. The strategies include availability of adequate social, family, professional, medical, peer/co-worker and organisational support. Therefore, if the basic support structure is laid out, then most workers diagnosed with PTSD and their families will be assisted to manage the health and social effects of PTSD and the effects of living with a member diagnosed with PTSD.

### **8.4.2 Qualifying statements**

The formulation of guidelines for a complex and sensitive health condition such as PTSD, gives little room to envisage every case. It is expected that in some cases, there will be valid exceptions to the approaches offered in the guidelines and sound reasons to deviate from the recommendations provided, given the merit of every PTSD case.

#### **8.4.3 Description of the implementation strategy**

The office of Employee Health and Wellness within the SAPS organisation has the main responsibility of ensuring and promoting the good health and wellness of workers and their immediate family members. Other organisational support structures include the workers' immediate commanders as well as HRM personnel who administratively work closely with workers diagnosed with PTSD and the management at station/unit, cluster, provincial and national levels. The workers' immediate families also serve as part of the main support base for the workers diagnosed with PTSD. Received family support enhances the workers' wellbeing and subsequently their performance at work becomes enriched.

The guidelines will first be presented to the SAPS management and EHW management forums in the Mahikeng area, the SAPS North-west provincial headquarters in Potchefstroom and the SAPS Head office in Pretoria to advocate and solicit the adaptation and implementation. They are later presented to the family members as they also have a critical role to play in supporting the SAPS worker who is largely at the receiving end of care and support offered by the SAPS organisation to effectively manage the effects of PTSD. It is envisaged that the SAPS management will mobilise a stakeholders discussion session to review, analyse and critic the guidelines, with a view to adapting and eventually adopting them for implementation within the SAPS workplace.

#### **8.4.4 Guidelines on the dissemination plan**

After adaptation and adoption by the organisation, the research findings and guidelines will be disseminated to all role players and end users. These role players and end users includes the SAPS management, the SAPS workers diagnosed with PTSD and the ones not diagnosed as such, the SAPS EHW personnel, the immediate family members and the labour unions representatives within the SAPS organisation. The dissemination will be through presentations at health and wellness seminars, workshops, national and international conferences, meetings and at general station and unit lectures within the SAPS workforce. Guideline distribution techniques will include the SAPS institutional website (intranet), UNISA's website,

publication in accredited journals, and printing and distributing copies to those with no access to the internet to ensure adequate accessibility.

## **8.5 CONCLUSIONS**

This chapter discussed in detail the development of proposed guidelines for the management of PTSD among the SAPS workers and their immediate family members. In view of the above, the purpose of this study has been achieved. The guidelines envisaged to contribute to the management of PTSD in Mahikeng area were developed from the components of the WTM and informed by the findings of the current study.

The guidelines sought to establish a supportive, accommodative and inclusive work and family environment within the SAPS organisation to enhance coping for both workers and families.

These guidelines were developed at a crucial time when community members are questioning the psychological wellbeing of the SAPS workers given the recent media reports on unacceptable police conduct and questionable ways of handling criminal cases. The guidelines also came at an important time when the police National Commissioner and Minister have raised their great concern about the health and wellness of the SAPS workers. Strict adoption and steadfast implementation of these guidelines would indeed serve as a necessary resource material for the Mahikeng SAPS organisation to develop and advance supportive policies and programs consistent with the principles of the Wits Trauma Model.

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**ANNEXURE 1**

**PARTICIPANTS' INFORMED CONSENT LETTER**

## **ANNEXURE 1: STUDY PARTICIPANT CONSENT FORM IN ENGLISH**

Statement regarding participation in a Research Project

Name of Study

### **GUIDELINES FOR MANAGEMENT OF POST TRAUMATIC STRESS DISORDER (PTSD) AMONG SOUTH AFRICAN POLICE SERVICE WORKERS IN MAHIKENG, NORTH WEST PROVINCE.**

#### **DEAR STUDY PARTICIPANT**

This study is conducted with the aim of assessing the effects of PTSD as experienced by the SAPS workers in Mahikeng area, and to develop guidelines for its management. The objectives of this study are to describe the socio-demographic characteristics of SAPS workforce who are diagnosed with PTSD, identify and describe work and non-work related traumatic incidents associated with possible PTSD development among the SAPS workers in Mahikeng, calculate life-time prevalence of PTSD among SAPS workers in Mahikeng, assess the health and social effects of PTSD as experienced by the SAPS workforce in Mahikeng, determine and describe the available onsite occupational health programs to deal with PTSD for SAPS workforce in Mahikeng, determine participants coping with the effects of PTSD, determine participants' opinions and recommendations for PTSD management, and develop guidelines to manage PTSD among SAPS workforce in Mahikeng and to implement the guidelines to manage PTSD among SAPS workers in Mahikeng.

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I have read the information on the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way.

I understand that participation in this study is completely voluntary and that I may withdraw from it at any time and without supplying reasons. This will have no influence on the regular work that I do as a police member. I was informed that the duration to participate in this study (interview session) will be approximately 45 minutes of my time.

I was informed that this study has been approved by the Research and Ethics Committee of the University of South Africa (UNISA) and that the SAPS have granted permission that the study should be conducted in my station/unit. I am fully aware that the results of this study will be used for scientific purposes only and may be published and that the information given by me will be treated with anonymity and confidentiality. I agree to partake in this study, provided my privacy is guaranteed.

I hereby give consent to participate in this study.

Place .....

Date.....

#### **Statement by the Research project leader**

I provided written information regarding this Study.

I agree to answer any future questions concerning the study as best as I am able.

I will adhere to the approved protocol.



Name of research project leader.....Signature.....Date.....  
Place.....

**Project leader Contact Number: 082 8240 171**

**Email Address: Shirleymaabela@gmail.com**

**ANNEXURE 2**

**LETTER OF REQUEST FOR PERMISSION TO CONDUCT A STUDY IN THE SAPS ORGANIZATION**

## **ANNEXURE 2: LETTER OF REQUEST FOR PERMISSION TO CONDUCT A STUDY IN THE SAPS**

**Enquiries: Shirley Mmapula Maabela: (018) 397 4189/ 082 82 40171**

- |           |   |                               |
|-----------|---|-------------------------------|
| <b>A.</b> | <b>THE PROVINCIAL HEAD<br/>PERSONNEL SERVICE<br/><br/>POTCHEFSTROOM</b>                   | <b>ATT. BRIG. D. MANAMELA</b> |
| <b>B.</b> | <b>THE PROVINCIAL HEAD<br/><br/>EMPLOYEE HEALTH &amp; WELLNESS<br/><br/>POTCHEFSTROOM</b> | <b>ATT. COL. T. MOFAMERE</b>  |
| <b>C.</b> | <b>THE PROVINCIAL HEAD<br/><br/>STRATEGIC MANAGEMENT<br/><br/>POTCHEFSTROOM</b>           | <b>ATT. COL. HEILBRON</b>     |
| <b>D.</b> | <b>THE CLUSTER COMMANDER<br/><br/>MAFIKENG</b>  | <b>ATT. BRIG. R. MOATSHE</b>  |
| <b>E.</b> | <b>THE STATION COMMANDER<br/><br/>MAFIKENG</b>  | <b>ATT. BRIG. M. MBONGO</b>   |

**SUBJECT: REQUEST FOR PERMISSION TO CONDUCT A STUDY IN SAPS: MAFIKENG: NO. 2125085-5 CAPT. (PSYCHOMETRIST) S. MAABELA FROM EHW: PSYCHOLOGICAL SERVICES: MAFIKENG.**

1. I hereby request your office to grant me permission to conduct a study in the SAPS Mafikeng Cluster.
2. I am currently registered with the University of South Africa (UNISA) for DLitt et Phil (Phd) in Health Studies (Please see attached proof of registration), and would like to pursue a study in the SAPS.
  - 2.1. As an Employee Health and Wellness practitioner, I have a concern about the Health and Wellbeing of SAPS members given the nature of their work, which is demanding both physically and psychologically. The nature of their work expose them to trauma which, if not effectively managed could lead to psychological ailments such as Depression, Post Traumatic Stress Disorder (PTSD), Suicide, personal (marital) and work-related problems etc. It is also my professional responsibility to conduct research in my field of specialization to address identified issues/ aspects of concern, and come up with recommendations on ways of effectively addressing the concerns, all with the aim of ensuring good health and wellness in the SAPS.

- 2.2. I conducted a study on Trauma Debriefing and Debriefing services in the SAPS during the past year (2010), as part of my Masters programme in Public Health (MPH) whereby I looked at the perceptions and experiences of SAPS members regarding trauma and debriefing services. I have submitted the findings of the study to National Head Office: Strategic Management as per their request, and still awaiting permission from Head Office to share the information in this regard. The findings will be made available to your office as soon as I receive a go ahead from Head Office.
- 2.3. It is my wish to further study about the aspect of Post Traumatic Stress Disorder (PTSD), which goes hand in glove with trauma and stress within the SAPS. The latter issue seems to be of major concern to some of us within our organization, also highlighted as key and an area requiring attention by the National Commissioner for police, in Pretoria News Paper, dated 2011-05-10, after recent media reported police activities which involved deaths of community members. I have identified a research topic which will assist in yielding relevant data to analyze and assist our fellow colleagues (Police members and their families), in managing PTSD, and also assist SAPS top management regarding alternative ways to support SAPS members in this regard. The identified topic is "Model for managing PTSD among SAPS workers: A health and Safety perspective".
- 2.4. The information shared by the members is always kept confidential by this office; the same will be applied with regard to this study.
3. Your permission in this regard will be much appreciated.
4. Please contact EHW: Psychological Services: Mafikeng office for enquiries.

**WITH KIND REGARDS**

**THANK YOU/KE A LEBOGA**

Original Signed

**CAPT. (PRINCIPAL PSYCHOMETRIST)**

**EMPLOYEE HEALTH & WELLNESS: PSYCHOLOGICAL SERVICES**

**MAFIKENG**

**S. M. MAABELA**

**ANNEXURE 3**

**APPROVAL TO CONDUCT RESEARCH LETTER FROM THE SAPS NORTH WEST PROVINCIAL  
COMMISSIONER**

ANNEXURE 3: APPROVAL TO CONDUCT RESEARCH LETTER FROM THE SAPS NORTH WEST  
PROVINCIAL COMMISSIONER

SUID-AFRIKAANSE POLISIEDIENS



SOUTH AFRICAN POLICE SERVICE

KGETSE KWA THOKO / PRIVAATSAK / PRIVATE BAG X801  
POTCHEFSTROOM, 2520

Palo Yame / Reference : 3/34/2  
Dipotsiso / Enquiries : Lieutenant General Mbombo  
Lt. Col Gotsiwe  
Mogala / Telephone : 018 299 7358  
Fekese / Fax number : (018) 299 7081

PROVINCIAL COMMISSIONER  
NORTH-WEST PROVINCE  
POTCHEFSTROOM  
2520

2011-08-01


- A The Provincial Head  
Personnel Services  
B Cluster Commander  
Mafikeng  
C Station Commander  
Mafikeng

Att: Brigadier Manamele  
Att: Brigadier Moatshe  
Att: Brigadier Mbongo

APPLICATION FOR AUTHORIZATION TO CONDUCT RESEARCH IN THE SOUTH AFRICAN POLICE  
SERVICE : NO 2126085-5 CAPTAIN MAABELA EHW PSYCHOLOGICAL SERVICES: MAFIKENG

1. Herewith please be advised that your request to conduct a research has been approved subject to the following conditions:
  - 1.1 The research be conducted at no cost to the state,
  - 1.2 Service Delivery may not be hampered at any stage during the research,
  - 1.3 No official transport and other state resources may be used for the duration of the research, and
  - 1.4 All conditions as prescribed within the National Instruction 1/2006 paragraph 6 must be strictly complied with.
2. Attached please find a copy of the National Instruction 1/2006 for your perusal and compliance.

Regards,

  
.....LIEUTENANT GENERAL  
PROVINCIAL COMMISSIONER: NORTHWEST  
M. Z. MBOMBO 2011-08-02

**ANNEXURE 4**

**APPROVAL TO CONDUCT RESEARCH LETTER FROM THE SAPS NATIONAL OFFICE RESEARCH  
TECHNICAL COMMITTEE: HEAD OF HUMAN RESOURCE DEVELOPMENT**

ANNEXURE 4: APPROVAL TO CONDUCT RESEARCH LETTER FROM THE SAPS NATIONAL  
OFFICE RESEARCH TECHNICAL COMMITTEE: HEAD OF HUMAN RESOURCE DEVELOPMENT

G.P.S. 002-0222

SAP 21

SOUTH AFRICAN POLICE SERVICE



SUID-AFRIKAANSE POLISIEDIENS

Verwysing Reference	11/3/1
Navrae Enquiries	General van Eyk Brigadier Gossmann
Telefoon Telephone	(012) 334 3813 (012) 334 3611
Faksnommer Fax number	(012) 334 3761

GENERAL RESEARCH AND CURRICULUM  
DEVELOPMENT  
HUMAN RESOURCE DEVELOPMENT

PRIVATE BAG X 177  
PRETORIA  
0001

Capt. Shirley Mmapula Maabela  
**EMPLOYEE HEALTH & WELLNESS: PSYCHOLOGICAL SERVICES**

**RE: REQUEST FOR PERMISSION TO CONDUCT A STUDY IN SAPS: MAFIKENG:  
NO. 2125085-5 CAPT. (PSYCHOMETRIST) S. MAABELA FROM EHW:  
PSYCHOLOGICAL SERVICES: MAFIKENG**

1. It is with pleasure to inform you that the Research Technical Committee situated in the Division: Human Resource development has granted you permission to conduct research within the South African Police Service.
2. The research to be conducted has to be in line with the topic presented, which is, "*An Intervention Model for Management of Post Traumatic Stress Disorder among South African Police Service Workers in Mafikeng, North West Province.*"
3. Furthermore, the permission for research conducted in the South African Police Service relies on the fact that the Provincial/Divisional Commissioner in which province or Division the research is to be conducted has granted the researcher due access.
4. Good Luck in the endeavour of your studies.

Yours sincerely,

**MAJOR GENERAL  
HEAD: GENERAL RESEARCH AND CURRICULUM DEVELOPMENT  
DIVISIONAL: HUMAN RESOURCE DEVELOPMENT  
M VAN EYK (DR)**

DATE: 2012-08-01.



**ANNEXURE 5**

**UNISA ETHICAL CLEARANCE CERTIFICATE**

## ANNEXURE 5: UNISA ETHICAL CLEARANCE CERTIFICATE



**UNIVERSITY OF SOUTH AFRICA  
Health Studies Higher Degrees Committee  
College of Human Sciences  
ETHICAL CLEARANCE CERTIFICATE**

**HS HDC 55/2011**

Date of meeting: 2 December 2011

Student No: 4921-715-1

Project Title: An intervention model for management of post traumatic stress disorder among South African Police Service workers in Mafikeng, North West Province.

Researcher: Shirley Mmapula Maabela

Degree: D Litt et Phil

Code: DPCHS04

Supervisor: Prof LI Zungu

Qualification: D Litt et Phil

Joint Supervisor: Prof HS Ngcobo

**DECISION OF COMMITTEE**

Approved



Conditionally Approved



  
Prof E Potgieter

**CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE**

  
Prof MC Bezuidenhout

**ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES**

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

## **ANNEXURE 6**

**DATA COLLECTION INSTRUMENT: INTERVIEW SCHEDULE: FOR THE SAPS WORKERS**

## **ANNEXURE 6: DATA COLLECTION INSTRUMENT: INTERVIEW SCHEDULE: FOR THE SAPS WORKERS.**

### **STUDY TOPIC: GUIDELINES FOR MANAGEMENT OF POST TRAUMATIC STRESS DISORDER (PTSD) AMONG SOUTH AFRICAN POLICE SERVICE WORKERS IN MAHIKENG: NORTH WEST PROVINCE.**

I am Shirley Mmapula Maabela conducting a study that aims at developing guidelines for the management of Post-Traumatic Stress Disorder (PTSD) among South African Police Service (SAPS) workers in the Mahikeng Cluster stations and units. The study participants include all workers of the SAPS organization, who have been diagnosed with PTSD and their immediate family members, thus wife/ husband (spouse) and dependents. I would like to ask you and your immediate family a few questions about your health condition: PTSD (in separate interview sessions), and the manner in which your condition is affecting your work, family and social life.

The information you will share will be used identify areas requiring attention in terms of developing guidelines for management of PTSD and identify alternative ways to support you as an employee of SAPS organization and your immediate family members. Your answers will be kept completely confidential and will not be shared with anyone. Anonymity is hereby guaranteed, no one will be able to identify your personal answers.

If you feel uncomfortable with any of the following questions, you do not have to answer. It is expected that the interview session will not take more than 45 minutes.

Language to be used: English

#### **I. SAPS MEMBER**

##### **SECTION A: SOCIO-DEMOGRAPHICS**

Kindly provide the following information in terms of your Demographics and Organizational Particulars

1. Age in years \_\_\_\_\_
2. Gender ☐ Male  
☐ Female
3. Marital status ☐ Single  
☐ Married  
☐ Widowed  
☐ Divorced

4. Ethnicity
- ☐ African
  - ☐ White
  - ☐ Colored
  - ☐ Asian
5. Home Language
- ☐ English
  - ☐ Afrikaans
  - ☐ Xhosa
  - ☐ Zulu
  - ☐ Sesotho
  - ☐ Setswana
  - ☐ Swati
  - ☐ Tsonga
  - ☐ Venda
  - ☐ Ndebele
  - ☐ Sepedi
6. Educational Qualifications
- ☐ Grade 12/ Std 10
  - ☐ Grade 12/ Std 10 with university exemption
  - ☐ 1 – 2 year diploma
  - ☐ 3 year degree/ diploma
  - ☐ Post Graduate
  - Other\_\_\_\_\_
7. Religion\_\_\_\_\_
8. Years of Service in SAPS\_\_\_\_\_
9. Rank\_\_\_\_\_

## SECTION B: INFORMATION RELATING TO PTSD DIAGNOSIS

Please provide detailed information regarding your work and health condition: PTSD

1. What does your work in the SAPS entail? I.e. what do you do in your work? Your Key responsibilities/ Performance areas?

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2. When did you get diagnosed with PTSD?

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3. What symptoms are you experiencing in relation to PTSD? Please mention

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4. Are you currently on medical treatment/programme: PTSD? **Yes / No**

If yes, - What treatment/ programme are you receiving?

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-For how long have you been on the treatment/ programme?

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5. How do you respond/ react to the treatment, any side effects experienced? **Yes/ No**

5.1 If yes, please mention

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5.2 Do you feel better since you have been on treatment/ programme in relation to the symptoms you initially experienced? **Yes/ No**

If No, Please elaborate

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6. According to your knowledge, what traumatic event caused PTSD? Please provide a detailed background history

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6.1. Was the traumatic event work or non-work related? Please provide detailed information

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7. How does PTSD affect the following areas of your life? Please elaborate.

**-Work life**

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**-Family life**

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**-Social life**

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8. How do you cope with and manage the effect that PTSD has in the following areas of your life?

**- Work**

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**-Family**

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**-Social life?**

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9. Are you currently receiving any professional assistance / counseling regarding PTSD? **Yes / No**

- 9.1. If yes, please provide the following: Do you consult with a professional? **Yes/ No**  
E.g. external professional/ resource i.e. a professional outside the SAPS or an internal professional/ resource (within the SAPS: e.g. EHW functionary?) If Yes, Please specify the profession

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- 9.2. If yes, how often do you report for consultation/ follow up/ support sessions?

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- 9.3. How do you experience the sessions? Please elaborate

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9.4. If your answer is NO in 8 above, what are your reasons for not consulting with a health professional? Please elaborate

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10. Have you attended trauma debriefing and management sessions offered by the SAPS Employee Health and Wellness (EHW) personnel before? **Yes / No**

10.1 If yes, when last did you attend?

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10.2. How often do you normally attend?

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10.3. How do you experience the trauma debriefing and management sessions?

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10.4. How relevant and effective do you think the trauma debriefing and management sessions are in helping you effectively cope with and manage PTSD?

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10.5. If no, what are the reasons for non- attendance?

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11. Have you applied for workman compensation for being diagnosed with PTSD?  
**Yes/ No**

11.1. If yes, have you been compensated in this regard? **Yes/ No**

11.2 If your answer is no at 11 above, what are the reasons for not applying?

12. In your opinion, what do you think the SAPS should do in order to help you and others to effectively manage PTSD?

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**END OF INTERVIEW SESSION. THANK YOU FOR YOUR ASSISTANCE.**

**ANNEXURE 7**

**DATA COLLECTION INSTRUMENT: INTERVIEW SCHEDULE: FOR IMMEDIATE FAMILY MEMBERS:  
SPOUSE, DEPENDENTS, PARENT AND SIBLING IN ENGLISH**

**ANNEXURE 7: DATA COLLECTION INSTRUMENT: INTERVIEW SCHEDULE:  
FOR IMMEDIATE FAMILY MEMBERS: SPOUSE & DEPENDENTS.**

**STUDY TOPIC: GUIDELINES FOR MANAGEMENT OF POST TRAUMATIC STRESS  
DISORDER (PTSD) AMONG SOUTH AFRICAN POLICE SERVICE WORKERS IN  
MAHIKENG: NORTH WEST PROVINCE.**

I am Shirley Mmapula Maabela conducting a study that aims at developing guidelines for the management of Post-Traumatic Stress Disorder (PTSD) among South African Police Service (SAPS) workers in the Mahikeng Cluster stations and units. The study participants include all members of the SAPS organization, who have been diagnosed with PTSD and their immediate family members, thus wife/ husband (spouse) and dependents. I would like to ask you few questions about your spouse/ parent's health condition: (in separate interview sessions), and the manner in which his/her condition is affecting his and your family /social life.

The information you will share will be used identify areas requiring attention in terms of PTSD management within the SAPS organization and identify alternative ways to support you as an immediate family member to the SAPS employee diagnosed with PTSD. Your answers will be kept completely confidential and will not be shared with anyone. Anonymity is hereby guaranteed, no one will be able to identify your personal answers.

If you feel uncomfortable with any of the following questions, you do not have to answer. It is expected that the interview session will not take more than 45 minutes.

Language to be used: English

**I FAMILY MEMBERS  
SECTION A: SOCIO-DEMOGRAPHICS**

Kindly provide the following information in terms of your Demographics

1. Age in years \_\_\_\_\_
2. Gender ☐ Male  
☐ Female
3. Marital status ☐ Single  
☐ Married  
☐ Widowed  
☐ Divorced

4. Ethnicity                      ☐ African  
    ☐ White  
    ☐ Colored  
    ☐ Asian
5. Relationship to              ☐ Spouse  
     SAPS member              ☐ Child  
    ☐ Sibling
6. Home Language              ☐ English  
    ☐ Afrikaans  
    ☐ Xhosa  
    ☐ Zulu  
    ☐ Sesotho  
    ☐ Setswana  
    ☐ Swati  
    ☐ Tsonga  
    ☐ Venda  
    ☐ Ndebele  
    ☐ Sepedi
7. Educational Qualifications      ☐ Grade 12/ Std 10  
    ☐ Grade 12/ Std 10 with university exemption  
    ☐ 1 – 2 year diploma  
    ☐ 3 year degree/ diploma  
    ☐ Post Graduate  
    Other\_\_\_\_\_
8. Religion\_\_\_\_\_

## SECTION B: INFORMATION REGARDING HEALTH CONDITION: PTSD

**Please provide detailed information regarding the health condition of your spouse/ father/ mother. (Guidelines below)**

1. Are you aware of the health condition of your spouse/ father/ mother? **Yes / No**

1.1 If yes, what is it called?

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1.2 Did He/ She explain it to you by him/herself or how did you learn / know about the health condition? Please elaborate

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2. If Yes, what effect does the current health condition: PTSD of your spouse/ father/ mother have on your family relations / life?

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3. How does the effect of living with a member diagnosed with PTSD make you feel?

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4. Please share with, any of the reactions you normally observe in your spouse/ parent resulting from living with a member diagnosed with PTSD

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5. What challenges do you experience as a family, resulting from living with a member diagnosed with PTSD?

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6. What is your role/ contribution do you offer as the family to help your spouse/ parent manage and cope with PTSD?

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7. How do you as a whole family cope with and manage the effects of living with a member diagnosed with PTSD?

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8. Are you receiving any form of professional assistance in this regard? **Yes/ No**

8.1 If Yes, Please specify/ elaborate

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9. What kind of assistance are you receiving from the SAPS organization in this regard?

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10. In your opinion, what can be done by the SAPS organization to help and support the members and families to effectively manage living with a member diagnosed with PTSD?

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**END OF INTERVIEW SESSION.THANK YOU FOR YOUR ASSISTANCE.**

## **ANNEXURE 8**

**DATA COLLECTION INSTRUMENT: INTERVIEW SCHEDULE: FOR IMMEDIATE FAMILY MEMBERS:  
SPOUSE,DEPENDENTS, PARENT AND SIBLING IN SETSWANA**



**ANNEXURE 8: DATA COLLECTION INSTRUMENT: INTERVIEW SCHEDULE:  
FOR IMMEDIATE FAMILY MEMBERS: SPOUSE, DEPENDENTS, PARENT AND  
SIBLING IN SETSWANA**

**TSHEDIMOSETSO KA GA THUTO - PATLISISO GO BA MALAPA A BADIREDI BA  
SEPODISI SA AFERIKA BORWA: MOLEKANE, BANA,  
MOTSADI MMOGO LE BOKGAITSEDI.**

**SETLHOGO SA THUTO – PATLISISO: TSELA YA GO THUSA GO TSHELA SENTLE  
KA MAEMO A BOITEKANELO AO A BAKIWANG KE GO LEBAGANA LE MAEMO  
AO A TSITSIBANYANG MMELE LE TLHALOGANYO (TSHOSANG) (PTSD),  
MAGARENG GA BADIREDI BA DITIRELO TSA SEPODISI SA AFERIKA BORWA  
MO KAROLONG YA MAHIKENG, POROFENSE YA BOKONE BOPHIRIMA.**

Leina la me ke Shirley Mmapula Maabela. Ke tshwaragane le thuto patlisiso mabapi le tsela eo e ka dirisiwang go thusa mapodisi ao dingaka di supileng fa ba tshwerwe le go amiwa ke maemo a boitekanelo ao a tlhagelelang mo mothong morago ga go lebagana le maemo ao a tshosang mo botshelong. Thuto – patlisiso e, e tobile mapodisi ao a dirang mo diteisheneng le dikarolwaneng tsa ditirelo tsa sepodisi tse di mo karolong ya Mahikeng, ga mmogo le ba malapa a bona, segolobogolo molekane le bana ba bone.

Dipotso le tshedimosetso ka ga thuto – patlisiso e, di tlile go bodiwa ka dinako tse di farologaneng magareng ga badiREDI ba sepodisi ba ba amegang le ba malapa a bone (Batsaya karolo). Kgangkgolo / thitokgang, ebile e le maikalelomagolo a thuto e, ke go bona tshedimosetso ka ga maemo a, a boitekanelo le gore a ama jang lona jaaka batsaya karolo mo matshelong a lona mo lolapeng le botshelo jwa botsalano.

Go solofetswe gore dintlha tseo o tla di tlhagisang di tla thusa thata go lemoga gore ke eng seo se ka tsenngwang tirisong go thusa mo lennaneng leo sepodisi se le dirisang go ka fokotsa le go tlosa kamo ya maemo a tsitsibanyang mmele / tshosang (PTSD) go badiREDI ba sona, le go neela tshegetso mo go bona mmogo le ba malapa a bone.

Dikarabo tsa gago di tsewa jaaka tshedimosetso e e botlhokwa e le ruri, mme ebile tshedimosetso e, e tla tsholwa ka sephiri se se tseneletseng. Ga go ope yo o tla itsing le go lemoga ka ga yona, ga o tshwanelwe ke go neela leina la gago gotlhelele. Seno, se thusa go fitlha tshedimosetso ya gago mo sephiring ka dinako tshotlhe.

Fa ka tsela nngwe o ka ikutlwa o sa sosologa go ka araba dingwe tsa dipotso tse ke tla di botsang, ga o pateletsege ka gope go dira jalo. Go solofetswe gore potso – patlo e, e tla tsaya nako e e ka fa tlase ga metsotso e le some a mane le botlhamo.

## **Loleme – tiriso: Setswana**

**Ba malapa a badiredi ba sepodisi: Molekane le bana.**

### **KAROLO YA NTLHA: MAEMO A LOAGO**

Ka kopo, neela tshedimosetso ka ga dintlha tseo di latelang mabapi le maemo a gago a loago:

1. Dingwaga tsa gago tsa botsalo di kae? \_\_\_\_\_
2. Bong jwa gago ☐ Monna  
☐ Mosadi
3. Boemo jwa gago jwa lenyalo ☐ Ke nyetse  
☐ Ga ke ise ke nyale/ ke nosi  
☐ Ke tladile/ lwe  
☐ Ke moswelwa
4. Kamano ya gago mabapi le leloko la sepodisi ☐ Molekane  
☐ Ngwana
5. Lotso lwa gago ☐ African  
☐ White  
☐ Colored  
☐ Asian
6. Puo ya lelapa ☐ English  
☐ Afrikaans  
☐ Xhosa  
☐ Zulu  
☐ Sesotho  
☐ Setswana  
☐ Swati  
☐ Tsonga  
☐ Venda  
☐ Ndebele  
☐ Sepedi

7. Diphitlhelelo tsa dithuto
- ☐ Grade 12/ Std 10
  - ☐ Grade 12/ Std 10 with university exemption
  - ☐ 1 – 2 year diploma
  - ☐ 3 year degree/ diploma
  - ☐ Post Graduate
- Nngwe gape\_\_\_\_\_
8. Tumelo / kereke\_\_\_\_\_

## KAROLO YA BOBEDI: TSHEDIMOSETSO MABAPI LE MAEMO A BOITEKANELO

Tswee – tswee, lotologa ka puo mabapi le maemo a boitekanelo a ga molekane/ motsadi wa gago. Dikaelo di a latela.

1. A o itse ka ga maemo a boitekanelo a ga molekane/ motsadi wa gago? **Ee/ Nyaa.**

- 1.1 Fa o arabile ka “Ee” mo go 1, fa godimo, ka kopo tthalosa gore maemo a, a bidiwa eng

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- 1.2 A molekane/ motsadi wa gago ke ene a go boleletseng/ tthalosediteng ka ga maemo ano (PTSD) ka boene, kgotsa o itsile jang ka ga one? Ka kopo tthalosa

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2. Fa o arabile ka “Ee” fa godimo, Ka kopo, tthalosa gore go tshela le wa lelapa yo dingaka di supilweng fa a amilwe ke PTSD go ama jang botshelo jwa lona mo lelapeng.

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3. Ka kopo tlhalosa gore go tshela le mongwe wa lelapa yo dingaka di supileng fa a na le PTSD go dira gore o ikutlwe jang?

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4. Ka kopo, tlhalosa gore o lemoga ditsibogo/ diphetogo dife mo botshelong jwa molekane/ motsadi wa gago tseo di ka tswang di tlholwa ke go tshela le wa lelapa yo go supilweng fa a na le PTSD.

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5. Ke dikgwetlho dife tseo lona jaaka lelapa lo di itemogelang ka ntlha ya go tshela le mongwe wa lelapa yo o nang le PTSD?

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6. Ke karolo efe eo o e tshamekang/ neelang jaaka lolapa go thusa le go tshegetsa molekane/ motsadi wa gago go kgona go tshela sentle ka PTSD?

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7. Lona lotlhe, jaaka lelapa, lo dira eng gore lo kgone go tswelela sentle ka botshelo le PTSD?

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8. A lona jaaka balelapa, lo amogela ditirelo tsa dithuso tsa porofeshenale, e ka tswa e le dithuso tsa tlhaloganyo, maikutlo/semoya kgotsa melemo ya ngaka mabapi le go tshela le wa lelapa yo o nang le PTSD? Ee / Nyaa

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8.1 Fa o arabile ka “Ee” mo go 8 fa godimo, ka kopo tthalosa ka botlalo mabapi le ditirelo tseo.

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9. Ke mofuta ofe wa thuso o ditirelo tsa Sepodisi sa Aferika Borwa se lo neelang o na mabapi le go tshela sentle le maemo a go tshela le wa lelapa yo o amilwneg ke PTSD? Ka kopo tthalosa.

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10. Ka kakanyo ya gago, ke eng seo se ka tsenngwang mo tirisong ke ditirelo tsa Sepodisi go netefatsa tshegetso le kemonokeng go badiredi ba ba amiwang ke PTSD mmogo le ba malapa a bona, ka maikalelo a go ba thusa go tshela sentle mabapi le PTSD? Ka kopo tthalosa.

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**BOKHUTLO. KE LEBOGELA THUSO YA GAGO.**

## ANNEXURE 9

### SAMPLE INTERVIEW

## **ANNEXURE 9: SAMPLE INTERVIEW**

**Legend: R- researcher, SP- study participant, PTSD- Post Traumatic Stress Disorder**

**R-** Are you aware of the health condition of you father?

**SP-** Yes.

**R-** If yes, what is it called?

**SP-** Post Traumatic Depression.... I don't know that term... Post traumatic Depression or what did you call it?

**R-** Post Traumatic Stress Disorder...?

**SP-** Yes... that.

**R-** Did he explain it to you by himself or how did you learn / know about the health condition? Please elaborate.

**SP-** We knew something was bothering him... He was diagnosed...He told us. After a while he started talking to us. His behavior was unusual, lonely, short tempered, high blood pressure... when he goes to the doctor he said he had depression. He came to a conclusion that his career triggered the whole thing.

**R-** If Yes, what effect does the current health condition: PTSD of your father have on your family relations / life?

**SP-** It has a major effect at this stage, he has PTSD, depression, high blood pressure, He is short tempered, does not think straight, not normal, something is bothering him internally. He has been spending time with his family... Working near home, near family, now they are separated by his career in the SAPS. Both my parents are now sick... The police has enemies within the community, for example a person can hold a grudge because a police apprehended him for a particular crime...my father has to work far from home now... my mom is left alone, she is vulnerable, but he is bound by his career, there is nothing we can do... my little brother has to go to school... The SAPS should be able to help... I think it is unfair and not right what the SAPS is doing. It is because of his police work to be where he is today... on top of that he is placed far from his family. I am restless at night... my mother has stress and depression and she is left alone because I am working away, my father is too, my little brother is attending college away from home...Surely the SAPS must be able to help in this regard...

**R-** How does the effect of PTSD make you feel?

**SP-** I feel a lot of things... I am hurt, angry... I have mixed emotions... there is nothing I can do... all I can do is hope for the best.

**R-** Please share with, any of the reactions you normally observe in your parent resulting from PTSD.

**SP-** Anger, somebody who does the kind of work he is doing, ends up being a danger to himself, and one day, because of his health condition, if he loses it, who is gonna be to blame? Is he gonna go to jail?

**R-** What challenges do you experience as a family, resulting from PTSD?

**SP-** A major one... SAPS is aware of this problem but nothing is being done. A problem of separation... Currently my parents are living far apart because of my father's job placement... It's much more difficult for our family to be together. There is no unity. Now that we are separated, my little brother complained that when he is home, my father is not home... he needs a father figure when he is growing up.

**R-** What is your role/ contribution do you offer as the family member to help your parent manage and cope with PTSD?

**SP-** I would help financially with major and other things... I would help to counsel...I counsel them when they have a problem; I am the first person they talk to... I can still think straight, they are not. They both have mental problems; they end up coming to me. He has applied for a post and did not get it after working hard and they moved him away from his family...He has to work, if he doesn't work what are we gonna eat now? I don't understand how the system works... but what can we say?

**R-** How do you as a whole family cope with and manage the effects of PTSD?

**SP-** It's sad... Everybody is lonely in the family because we are living far apart and in fear. Both my father's parents passed away due to stroke caused by high blood pressure... We cope by praying that things will be better, attending church and practicing religion has kept us where we are today...if we were to survive, that's the only thing that is helping us...if it was not for it, I don't know what would have happened.

**R-** Are you receiving any form of professional assistance in this regard?

**SP-**No

**R-** What kind of assistance are you receiving from the SAPS in this regard?

**SP-** I am not receiving anything form SAPS.

**R-** In your opinion, what can be done by the SAPS to help and support the members and families to effectively manage PTSD?

**SP-** Support, counsel them, check if everything is ok. SAPS should be aware of the health conditions of their employees. Keep an eye on him, but it's not happening. Colleagues keeping an eye on him, checking whether he is ok, nobody is doing anything in that direction... nothing is being done... hopefully you can help us with this study of yours.

**END**



**ANNEXURE 10**

**NEWS PAPER ARTICLE: COP STRESS-LEVEL TIME BOMB**

# Cop stress-level time bomb

## Compulsory trauma counselling mooted after killings

**S**OUTH AFRICA'S police service could have a potentially explosive problem on its hands if high stress levels within its ranks are not dealt with urgently. With an estimated 60 percent of physically injured police officers suffering from post-traumatic stress disorder (PTSD) and the SAPS "injuring" South African police, which, according to studies, has an estimated 25 percent of officers suffering from anxiety dis-

Petros, along with national police commissioner General Bektir Petrich, addressed police officers in Petrich or areas in a live broadcast. He stressed the need for the police to be seen to be fair and to be honest. He also stressed the need for the police to be seen to be honest and to be honest.

- First diagnosed among Vietnam veterans
- Three kinds: acute, chronic and delayed onset
- Symptoms: depression, extreme exhaustion, withdrawal from loved ones, loss of appetite
- Soldiers, war brides, active duty, war veterans, possible change

"There is a problem with members believing they will be negatively affected if they go for counseling, but management's idea is to give everyone a perspective of management or position is to do so, and it is to be done on a regular basis."

"We have regular counselling sessions but we rely on members voluntarily coming forward and going to the sessions."

"The reason is that they have either had previous injuries, or are affected by the fact that their colleagues have had similar experi-

His warning was echoed by Cole, who said the SAPS mirrored South African society.

"On top of their injuries, they are already under increased psychological strain, which is now compounded by their injuries," she said.

"Citizens need to look at themselves and ask why we are such a violent society, which in the last financial year saw more than 1500 people being murdered.

"The problem is that police members often don't know that they suffer from high stress levels because they are not aware of the symptoms."

...it is the police who are often on the receiving end of this brutality and while they have a right to protect themselves and defend people, they must understand that they are dealing to police with human rights. "It is a very fine balance," the

"Also, police officers are often during marriages; crises, told to be on the lookout for signs of stress yet they are not qualified to recognise the symptoms and where they do, they do not know how to deal with it." Dr. Rosenbaum.



national police commissioner General Bhaski Cate talks about the high stress levels suffered by members of the SA Police Service.